

DOCUMENT RESUME

ED 355 186

SP 034 236

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TITLE School-Based HIV Prevention: A Multidisciplinary Approach.
INSTITUTION American School Health Association, Kent, Ohio.
SPONS AGENCY Center for Chronic Disease Prevention and Health Promotion (DHHS/CDC), Atlanta, GA. Adolescent and School Health Div.
REPORT NO ASHA-Pub-H001; ISBN-0-917160-5
PUB DATE 91
CONTRACT U63/CCU502755-03
NOTE 73p.
AVAILABLE FROM American School Health Association, 7263 State Route 43, P.O. Box 708, Kent, OH 44240.
PUB TYPE Guides - Classroom Use - Teaching Guides (For Teacher) (052) -- Guides - Non-Classroom Use (055)
EDRS PRICE MF01/PC03 Plus Postage.
DESCRIPTORS *Acquired Immune Deficiency Syndrome; Agency Cooperation; Class Activities; Community Programs; *Disease Control; Elementary Secondary Education; *Health Education; Health Promotion; *Interdisciplinary Approach; Models; Peer Teaching; *Prevention; Preventive Medicine; Program Development; Teaching Methods

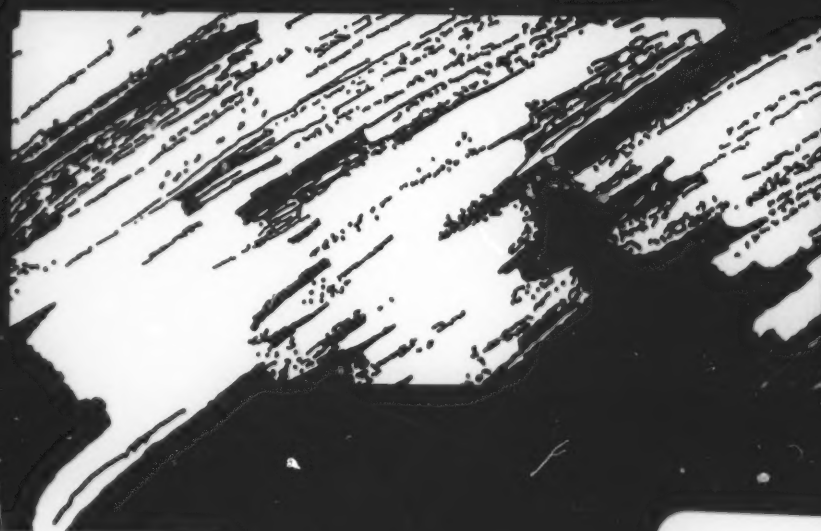
ABSTRACT

This manual was written to help school-based professionals implement school health education programs to prevent the spread of the human immunodeficiency virus (HIV). The manual provides a framework and plan to promote an interdisciplinary approach to HIV education in schools. The manual begins with a review of basic facts about acquired immune deficiency syndrome (AIDS) and the medical spectrum of HIV infection. The next chapter meshes educational and behavioral principles to present a theoretical base for multidisciplinary education. Prevention strategies for school and community are then presented, covering: the specialized roles of school and community personnel; suggested activities for each group; lists of resource organizations, books, videotapes, and other media; and sample program planning and evaluation sheets. Peer education is the focus of the next chapter, with steps in initiating a peer education program and descriptions of model programs. The final chapter presents student skills for prevention of HIV infection, including models and class exercises for teaching decision making, problem solving, refusal, communication, and assertiveness. Appendices provide disease prevention guidelines, curriculum evaluation criteria, library resource lists that cite and annotate 16 books for children and youth and 8 books for adults working with youth, a self-instructional packet (pretest and posttest), position statements, school district policies, and an education programming survey form. (JDD)

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School-Based HIV Prevention:

A Multidisciplinary Approach



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Federal Contract Number U63/CCU502755-03

Library of Congress Catalog Number 91-073197

ISBN Indexing Number 0-917160-5

ASHA Publication Number H001

Publication Date 1991

Cover/Interior Design: Kleidon & Associates, Akron, Ohio;

Typesetting: TypeWorks, Akron, Ohio;

Printing: Star Printing Inc., Akron, Ohio;

Copy Editing/ Proofreading: Charlene K. Reed.

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Abbreviations

The following is a list of commonly used acronyms and abbreviations contained in the manual.

AIDS—acquired immunodeficiency syndrome
 AAHE—Association for the Advancement of Health Education
 ASHA—American School Health Association
 AZT—azidothymidine (medical slang for zidovudine or the drug with the brand name Retrovir)
 CDC—Centers for Disease Control
 CPO—Center for Population Options
 EDC—Education Development Center
 EIA—enzyme immunoassay
 ELISA—enzyme-linked immunosorbent assay
 HIV—human immunodeficiency virus
 NAIC—National AIDS Information Clearinghouse
 NCAS—National Coalition of Advocates for Students
 NNRYS—National Network of Runaway and Youth Services
 NSBA—National School Boards Association
 PCP—*pneumocystis carinii* pneumonia
 PTA—Parent-Teacher Association
 PWA—person with AIDS
 STD—sexually transmitted disease

Foreword

During their late elementary and secondary school years, many young people begin to experiment with behaviors that place them at risk for infection with the human immunodeficiency virus (HIV). In 1987, the Division of Adolescent and School Health, Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control, initiated a national program to prevent further spread of HIV among youth. As part of this program, funds are awarded to national organizations to help schools and other youth-serving organizations provide HIV education within comprehensive school health education programs and coordinated community-based efforts.

In September 1987, the American School Health Association (ASHA) received a five-year cooperative agreement to develop an educational program targeted at school-aged children. As part of this program, ASHA wrote the present manual, *School-Based HIV Prevention: A Multidisciplinary Approach*, to help school-based professionals implement or improve school health education efforts to prevent the spread of HIV.

This manual promotes an interdisciplinary approach to HIV education in schools. It is designed for health educators, teachers from a broad range of disciplines, school nurses, counselors, school board members, and school administrators. These professionals can provide consistent HIV-prevention messages to students in a variety of settings. Activities designed to involve parents and community leaders in HIV-prevention efforts are also included in the manual.

Organized in 1927, ASHA has established a record of advocating and initiating comprehensive, high-quality school health programs that improve the health of children and youth. ASHA-advocated programs call for protective and supportive health services, health-enhancing learning experiences, and a healthful environment in our nation's schools.

This manual provides a plan and a framework, enabling school-based professionals to develop programs appropriate for their communities to protect youth from this deadly virus. To accomplish this goal, it is imperative that all school-based professionals put forth their best efforts.

Introduction

Acquired Immunodeficiency Syndrome (AIDS) was first reported in 1981. Within three years, scientists learned 1) that AIDS is caused by a virus, 2) that the virus is transmitted in specific ways, and 3) more importantly, that becoming infected with the virus can be prevented. As more became known about the virus (later called HIV), prevention efforts shifted from highly targeted education of gay men and persons with hemophilia, to education programs for all individuals, including youth, so that all persons could effectively eliminate or reduce their risk of HIV infection.

Educating America's youth about the deadly consequences of HIV infection and motivating them to change attitudes and behaviors that may put them at risk for HIV infection is a challenge all school-based professionals must accept. Two facts are clear. One, the nation's youth are at risk. Two, schools are an ideal place to reach them.

As of the end of December 1990, there were 629 cases of AIDS reported in adolescents aged 13 to 19 years¹. The numbers increase substantially when older youth are included. For example, of AIDS cases reported through December 1990, 7,349 had been reported among persons aged 13 to 24 years and twenty percent of all AIDS cases reported in the United States were among persons aged 20 to 29 years¹. In addition, as of the end of December 1990, CDC reported 14% of adolescents aged 13 to 19 with AIDS were infected with HIV through heterosexual contact¹.

As demonstrated by the above statistics, and contrary to the impression conveyed by the relatively small number of reported AIDS cases among persons aged 13 to 19 years, HIV infection among adolescents is an important public health problem. The scope of the problem is expected to get worse without effective intervention. Population-based estimates of HIV infection among youth are not available. However, available data from selected subgroups (e.g. Job Corps) document high prevalence rates among some youth. In addition, AIDS case reports among 13 to 19 year olds underestimate the prevalence of HIV infection in this age group because of the virus' long incubation period. For this reason, AIDS cases among 13 to 29 year olds are the best indicator of the magnitude of this problem among adolescents. Unfortunately, if prevention efforts are not successful, there is already a sizeable reservoir of youth with HIV infection from which new infections and AIDS cases will arise in the future.

Risk-Taking Behaviors

Adolescence is a time of experimentation and risk taking. Associated with that experimentation is sexual activity, the major factor for HIV infection.

Several studies document that a significant proportion of teenagers engage in sexual intercourse. In 1986, an estimated 11.6 million youth aged 13 to 19 had had sexual

intercourse². By age 20, an estimated 70% of females and 80% of males report having had intercourse². The average age for females to report first intercourse is 16.2 years; for males, 15.7 years³.

In 1989, data reported to the Centers for Disease Control (CDC) from state, territorial and local education agencies in 30 states, 10 cities, and two territories showed that 27% to 76% (median 56%) of high school students reported having had sexual intercourse at least once. In addition, 7% to 40% (median 21%) reported ever having had four or more sex partners⁴.

Not only are students sexually active, they apparently have unprotected sex. Four of 10 females become pregnant before age 20, and nearly half of persons with sexually transmitted diseases (STDs) are under age 25⁵. A random sample of Massachusetts teens revealed that although 70% reported they were sexually active (having intercourse or other sexual contact), only 15% had changed their sexual behavior because of concern about contracting HIV⁶.

A further complication to prevention efforts is that many teens lack knowledge about the protective value of condoms⁷. Although abstinence eliminates risk of infection through sexual exposure, condoms are also effective in preventing HIV infection as well as other STDs. Only 60% of San Francisco high school students recently surveyed were aware that condoms are effective in preventing HIV infection⁸. Of teen females who used contraception, only 22% used condoms; the rest used other methods that offer no protection against the HIV or other STDs⁹.

Drug use and abuse is another risk behavior for HIV infection. Any drug abuse (including alcohol, marijuana, and cocaine) contributes to HIV infection by impairing students' judgement, leaving them vulnerable to succumb to other risky behaviors. Intravenous (IV) drug abuse exposes youth to HIV-infected blood through shared needles, syringes and other equipment.

Estimates of IV drug use among high school students vary. A study conducted by the National Institute on Drug Abuse in 1986 indicated 1.1% of United States high school seniors reported they had used heroin¹⁰. Data reported to CDC by state, territorial, and local education agencies in 1989 showed that 2% to 5% of students (median 3%) reported ever injecting cocaine, heroin, or other illegal drugs and 0.2% to 3% (median 0.9%) reported sharing needles used to inject any drugs⁴.

The Schools' Role

Schools are in a pivotal position to address HIV prevention since they have the capacity to reach 95% of the nation's youth. CDC has recommended that state departments of education implement programs to help schools provide education to correct misconceptions about



HIV transmission; to help youth develop skills to avoid becoming infected with HIV; and to help schools integrate such programs within more comprehensive programs of school health that provide a basis for understanding the relationship between behavior and health.

The former U.S. Surgeon General, C. Everett Koop, MD, recommended education as the primary prevention effort. Urging that AIDS education begin early in the academic program, Dr. Koop said, "...our youth are not receiving information that is vital to their future health and well-being...this silence must end"¹¹.

The Presidential Commission on the Human Immunodeficiency Virus Epidemic concurred with CDC and the former Surgeon General, advocating both short-term, immediate HIV education and long-term, comprehensive health education to respond to the epidemic¹². The commission—composed of education, religious, medical and governmental leaders—recommended that students be provided with current and accurate information so they can make informed decisions about their behavior and avoid actions that put them at risk. According to commission members, school-based education should also highlight the benefits of character development, abstinence, and monogamy.

The Manual as a Resource Tool

To help teachers, counselors, nurses, physicians, psychologists, worksite wellness directors, administrators, community groups, and parents take on this monumental challenge, this manual does the following:

- Provides basic information about AIDS and the medical spectrum of HIV infection.
- Outlines guidelines to improve the quality of HIV education programs.
- Describes strategies and suggested student activities, incorporating HIV education into a variety of subject areas.
- Offers "how-to's" for developing a peer education program.
- Reviews such student skills as decision making, problem solving, refusal, communication, and assertiveness.

Chapter One provides basic facts about AIDS and the medical spectrum of HIV infection. It describes the epidemiology of AIDS and HIV infection, the methods by which the virus is transmitted and can be prevented, and how HIV infection is detected in laboratory tests.

In Chapter Two, educational and behavioral principles are meshed, presenting a theoretical base for multidisciplinary education. Instructional variables, student aptitude, and environmental factors are examined. The chapter stresses the importance of consistent and accurate messages across the curriculum, in the home, and throughout the community.

Chapter Three, "HIV Prevention Strategies for School and Community," is the heart of the manual. The chapter begins by presenting a program planning model for a communitywide response. The specialized roles of teachers of a variety of disciplines, nurses, physicians, counselors, worksite wellness directors, administrators, community groups, and parents are described. Suggested activities for each group are presented. Resource organizations, books, videotapes and other media are identified. To help readers

implement the ideas, sample planning sheets are included. Finally, evaluation is discussed and sample program evaluation sheets are provided.

Peer education is the focus of Chapter Four. Since peer education and support are highly influential, the chapter includes steps for initiating a peer education program. It also describes several model programs and identifies sources for more information.

Chapter Five presents student skills for the prevention of HIV infection. Students must possess skills in decision making, problem solving, refusal, communication, and assertiveness to deal with the pressures and behaviors that may put them at risk. The chapter outlines models for students to use to make their choices and includes suggestions for in-class exercises.

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Chapter I:

HIV: the Spectrum of Infection, Transmission, and Prevention

The current number of reported AIDS cases represents only a fraction of persons already infected with HIV. CDC estimates that one million Americans are infected with HIV. During 1990, 43,339 cases of AIDS were reported to CDC¹. The annual count of diagnosed AIDS cases is predicted to increase to between 61,000 and 98,000 during 1993².

Globally, the outlook is even worse. The World Health Organization estimates the number of HIV-infected people worldwide to be 5 million to 10 million. If 10% to 30% of those infected develop AIDS over the next five years, 500,000 to 3 million new cases of AIDS could emerge³. Prompt and effective educational programs are vital to preventing the spread of the deadly virus. (To get an update on the demographics of reported AIDS cases in the United States, readers may obtain single copies of the CDC **HIV/AIDS Surveillance** report by writing to the National AIDS Information Clearinghouse (NAIC), P.O. Box 6003, Rockville, Maryland 20850.)

The Medical Spectrum of HIV Infection

HIV, which previously has been called HTLV-III, LAV, and ARV, is one of many viruses in a group called retroviruses. HIV infection causes a wide spectrum of conditions, ranging from asymptomatic (no symptoms) HIV infection to life-threatening cancers and opportunistic diseases in persons with diagnosed AIDS. AIDS is the severest manifestation of HIV infection. Symptomatic (with symptoms) HIV infection includes not only AIDS but a range of usually milder illnesses. A comprehensive and technical presentation of the CDC's classification system, which is revised from time to time as more medical information becomes available may be found in the Centers for Disease Control publication *Morbidity and Mortality Weekly Report (MMWR)*⁴. However, this information is too detailed for lay audiences seeking practical information about how to avoid HIV infection and is not essential for this purpose. (Those who wish to subscribe to *MMWR*, may obtain subscription information from the NAIC address above).

Modes of Transmission

Although HIV has been found in several body fluids, only four have been implicated in transmitting the virus: blood, semen, vaginal secretions, and the breast milk of mothers infected with HIV. Babies of women infected with HIV also may acquire the virus before or during birth.

Behaviors that put one at risk for contracting HIV include 1) engaging in vaginal, anal, and possibly oral intercourse without the proper use of a latex condom, and 2) sharing needles and syringes that may be contaminated with infected blood. Students who share needles for *any* purpose—to inject drugs or steroids or even to pierce ears—are at risk. Needles used for tattooing also present a danger if they are not sterile.

HIV is *not* transmitted through saliva, sweat, tears, urine, or feces. HIV is *not* transmitted by social kissing such as kissing with a closed mouth or kissing on the cheek. Sexual kissing (open mouth or "French") may pose a theoretical risk of transmission of HIV because of the possible exchange of blood. The Public Health Service still recommends against this practice with an infected person. HIV is *not* contracted from shared eating utensils, from toilet seats, or from mosquitoes or other insects⁵.

Blood donors face no risk of HIV infection from the equipment used to collect blood. Sterile needles are used for each donor. In the past, there was a risk of acquiring the virus through receipt of blood transfusions and clotting factors used by persons with hemophilia. However, since March 1985 all donated blood and plasma undergoes a two-phase screening procedure that excludes donors who are likely to be infected with HIV or other disease agents, and uses the HIV antibody test to remove HIV positive blood from the blood supply. Donors who, after giving blood, have reservations about its safety, may indicate discretely that their blood should not be used. Blood products for persons with hemophilia are now heat-treated to kill any HIV that might slip through the screening processes. These procedures, combined with the HIV antibody test, have greatly improved the safety of the blood supply.

HIV Antibody Test

Several laboratory tests exist for detecting HIV infection. After infection, HIV antibodies develop and circulate in the blood. They can be detected by HIV antibody tests, such as the enzyme-linked immunosorbent assay (ELISA) or enzyme immunoassay (EIA) or other techniques. These tests usually are used to provide the initial screening for HIV infection.

No medical test is foolproof. Any test may yield false-positive results. With a false-positive ELISA result, uninfected blood would test positive. Fortunately, this is an unusual occurrence. False-positive results have been found among uninfected people with certain immunologic

disturbances other than AIDS and some who have had multiple blood transfusions⁶. However, false-positive results are readily detectable with further laboratory testing.

False-negative results—infected blood that tests negative—may also occur. Most often, these results appear in tests of newly infected persons who have not yet developed HIV antibodies⁶. Research indicates it generally takes two to twelve weeks from the time of infection for enough antibodies to HIV to develop. For a few individuals, it may take up to six months.

For those whose initial test result is positive, a second ELISA is conducted. If the results are repeatedly positive, results are "confirmed" with a more specific test—usually the Western blot assay⁷.

HIV infection does not mean a person has AIDS. However, scientists have determined that the percentage of HIV-infected persons that will eventually develop AIDS is very high. Without treatment, scientists have observed that most infected persons develop AIDS within 7 to 10 years of infection, but some asymptomatic persons have remained healthy for several years after their infection was confirmed. At least one medication, zidovudine, commonly known as azidothymidine (AZT), is now known to delay the onset of severe HIV-related medical problems.

With few exceptions, the decision to be tested for HIV infection is a personal choice. Test information, counseling, and blood testing are all available from public health departments in every state. You can find the address of the site near you by telephoning the U.S. Public Health Service/AIDS Information Line at 1-800-342-AIDS, Spanish (SIDA) 1-800-344-7432 and TTY 1-800-243-7889. U.S. military personnel are required to take the HIV antibody test. Mandatory testing also has been proposed and implemented in some states for other groups, such as prison inmates, and persons convicted of sexual crimes. Peace Corp and Job Corps applicants undergo mandatory testing as must some international travelers.

Persons who have engaged in high-risk behaviors are encouraged to be counseled and tested, both as a means to maintain behaviors that prevent future infection or the infection of others. As new medical treatments become available, individuals who know they are infected with HIV will be able to begin treatment.

Those who test positive should abstain from sex or use latex condoms every time they have sex. Using spermicides such as nonoxonyl-9, an ingredient which has been shown to kill HIV in laboratory tests, may be helpful in further reducing risk of transmission for those who already use condoms.

An individual may choose from a variety of locations for HIV antibody testing (e.g., doctor's offices, hospitals, State or local health departments, anonymous or confidential testing sites, public health clinics). Basically there are two types of testing sites, those where the individual is assigned a code number and their name is not recorded (anonymous) and thus cannot be connected with results, and those where the individual's name is recorded and the information is kept confidential. Regardless of where the test is conducted or its results, an individual should receive both pre- and post-test counseling and be informed and give consent for testing.

Medical Benefits and Social Consequences of HIV Antibody Testing

Recently, the medical benefits of early diagnosis of HIV infection have increased due to improved treatments. HIV antibody testing is critical to this early diagnosis of HIV infection⁸. Early diagnosis has many advantages. Those who are aware of a positive HIV antibody status may alter their behaviors to prevent further transmission of HIV. (It should be noted, however, that an individual need not be aware of their HIV antibody status to alter their behaviors in order to prevent the possible transmission of HIV.) Early diagnosis makes earlier treatments possible. We know that AZT prevents the onset of AIDS in HIV-infected persons even though they may have no symptoms. Furthermore, it has been recommended that all persons infected with HIV be screened for tuberculosis so that they may be treated early. Syphilis may be more difficult to treat in patients infected with HIV so an early diagnosis would be beneficial in this case as well. Persons infected with HIV should be offered vaccines that can prevent infections such as influenza or certain types of pneumonia. These infections can be life-threatening to the person with a compromised immune system⁹.

Finally, to meet the CDC case definition of AIDS, persons may need to meet the criterion of a positive HIV antibody test. Without proof of a positive test, they may not be eligible for certain benefits⁹.

For persons who seek HIV antibody counseling and testing, some civil liberties groups and other concerned citizens recommend anonymous testing sites. Some public health officials also recommend testing at a site where the test results are kept strictly confidential and medical follow up is assured. However, whenever one's name is connected with results, a potential for discrimination exists. For example, according to Lo et al., optimal medical diagnosis and treatment require that HIV antibody test results be noted on the medical record and disclosed to other health care workers. Although medical records are confidential, they may be accessible to hospital employees not involved in patient care and to insurers. This information may also need to be disclosed on insurance applications which may lead to denial of coverage or extremely high insurance premiums¹⁰. Until HIV-related discrimination is eliminated, anonymity and confidentiality will be needed to protect infected persons from extreme consequences such as losing their jobs, housing, insurance coverage, and friends.

Medical Treatment of HIV Infection

AIDS is a disease without a cure; HIV infection is treatable to limited extent, but no medicine has eradicated the infection in any patient. No immunization to prevent HIV infection exists, although early experimental trials of possible vaccines are underway. However, any potential vaccine will require years of study to determine effectiveness and safety.

The majority of AIDS-related deaths are due to opportunistic infections and cancers. Although no cure for AIDS exists, some opportunistic diseases related to AIDS are treatable. Medical regimens are in use for less serious infections such as oral thrush as well as some major, life-threatening infections such as *Pneumocystis carinii* pneumonia (PCP). However, the germs may become

resistant to treatment over time, side effects of medicines may occur, or multiple infections may occur simultaneously and render some forms of treatments ineffective.

Several experimental trials of new drugs to treat opportunistic infections are underway. Zidovudine, also known as Retrovir and AZT, has been successful in prolonging the lives of persons with AIDS (PWAs), especially those who have recovered from a bout of PCP. In early 1990, data were published showing AZT to be effective in delaying the onset of AIDS in those infected with HIV¹⁰. Its success has fueled the search for more drugs that may reduce the wide-ranging complications of immunodeficiency. Several other such drugs are in clinical use.

Prevention

HIV infection is preventable. Education and behavior change are primary means to prevent infection. Schools and other youth-serving organizations can help youth avoid HIV infection by encouraging and enabling them to do the following:

- Abstain from sex until able to establish a mutually monogamous relationship with an uninfected partner.
- Refrain from injecting drugs and sharing needles. Those who are unwilling to stop engaging in risk behaviors should be encouraged to do the following:
 - Use a latex condom with a spermicide such as nonoxynol-9. Condom use is safer if a water-based lubricant such as K-Y jelly is used concurrently. Water-based lubricants protect the condom against damage from friction and protect body tissues from damage. Oil-based lubricants such as petroleum jelly should not be used, since they may cause the condom to quickly deteriorate.
 - Seek treatment if using illicit drugs. Never share needles or other injection equipment.^{11p. 47}

The next two chapters offer a theoretical framework and practical strategies for a successful school-based HIV education program. In Chapter Two, basic educational and behavioral principles that promote learning and behavior change are applied to HIV education. Strategies for effective

HIV instructional programs that incorporate a multidisciplinary approach are provided in Chapter Three.

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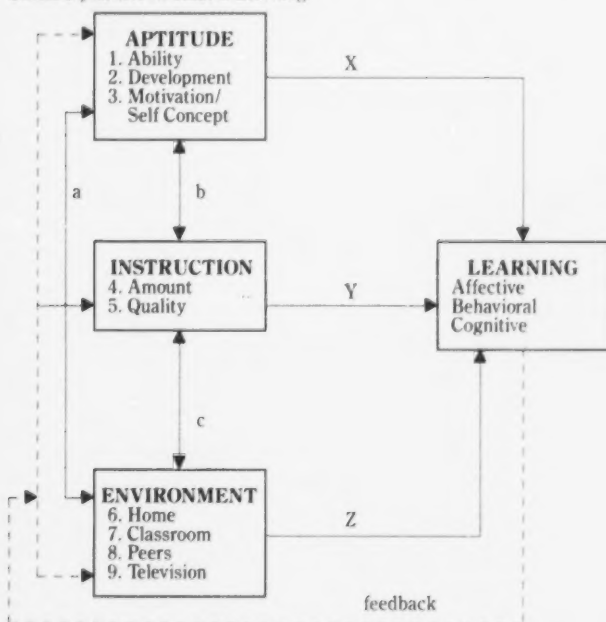
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Chapter 2: Essential HIV Education Principles

HIV prevention programs, like all health education efforts, should incorporate knowledge about the general learning process and take into account the variables that explain health behavior. Educational theorists have determined that instructional and environmental variables as well as student aptitude have profound effects upon affective (concerning attitudes), behavioral (concerning skills) and cognitive (concerning knowledge) learning¹. As shown in Figure 2.1, the major direct causes of learning include a student's ability, developmental level, and motivation/self concept; the amount and quality of instruction; and the psychological environment of the student, including influences of the home, classroom, peers, and media.

Figure 2.1

Causal Influences on Student Learning



Aptitude, instruction, and the psychological environment are major direct causes of learning (shown as double arrows X, Y, Z). They also influence one another (shown as arrows a, b, c), and are in turn influenced by feedback on the amount of learning that takes place (shown as broken arrows).

Adapted from Walberg, HJ. Improving the productivity of America's schools. Educational Leadership 1984. 41(6) 19-30.

In a review of the health behavior literature, six factors emerged as critical to health behavior: knowledge about the disease; social interactions, social norms, and social structure; perceived threat of illness; accessibility to health services; attitudes about health care; and demographic factors².

Allensworth and Symons³ applied those factors associated with general learning and health behavior to HIV prevention. The following HIV education principles, derived from their work, provide theoretical constructs for developing educationally sound intervention programs to reduce transmission of HIV infection.

HIV infection prevention programs should accomplish the following:

- Address the varying cognitive and developmental levels of students.
- Promote a healthy self concept.
- Repeat the content throughout the K-12 curriculum.
- Provide quality instruction.
- Involve parents and families as partners in the instructional experience.
- Use adult and student interaction in the classroom setting to reinforce formal and informal HIV infection prevention or education messages.
- Use students as active partners in the instructional process.
- Counter sexually irresponsible mass media messages with more responsible messages.
- Develop strategies that raise students' awareness of the risk of HIV infection.
- Develop strategies to provide access to health services and, to foster (as needed) positive attitudes about health care.
- Provide appropriate interventions for populations at greater risk.

Student Aptitude Variables

HIV education programs should address the varying cognitive and developmental levels of students.

Students display different cognitive and psychological characteristics as they develop and mature. Educational planners should be aware of and accommodate these differences.

A wealth of HIV educational materials has been developed for students with normal mental and physical abilities. These materials may be accessed through the Combined Health Information Database, AIDS Subfile, or the National AIDS Information Clearinghouse (NAIC). NAIC distributes free materials to educate young people

about HIV infection and AIDS. Brochures, fact sheets, posters, and guides targeted to youth and their parents are available from the Clearinghouse at 1-800-458-5231.

Currently, few resources are designed for those with special learning needs. Several organizations, however, are striving to fill this gap.

For example, the Young Adult Institute (YAI) in New York is an agency that provides quality services to people with mental retardation and developmental disabilities and their families. As part of its AIDS Professional Education Program (APEP), YAI has developed an AIDS staff training program for New York City-based agencies who work with people with mental retardation and/or developmental disabilities. This program is free of charge and provides New York City agency representatives with the skills, beginning materials, program models, and information necessary to develop effective AIDS prevention education programs for clients who function in the mild to moderate ranges. YAI has also developed a training video and manual titled "AIDS: Training People with Disabilities to Better Protect Themselves." This training video and manual provides comprehensive step-by-step instructions on how to teach people with disabilities about the hazards of AIDS and how to better protect themselves. The videotape is pragmatic, explicit, sensitive, and employs a multi-sensory approach. (The manual and video are also available in Spanish.) For more information contact the AIDS Professional Education Program, Young Adult Institute, 460 West 34th Street, New York, NY 10001; (212) 563-7474.

To identify criteria for effective HIV education programs for deaf and hearing-impaired students, the American

College Health Association is collaborating with health care professionals from Gallaudet University, a higher education institution founded for the deaf and the hearing impaired. For more information contact the HIV education staff of the American College Health Association, 1300 Piccard Drive, Suite 200, Rockville, MD 20850; (301) 963-1100.

To address the special needs of children and youth with disabilities, the Association for the Advancement of Health Education (AAHE) and the Council for Exceptional Children have joined forces on a project. The project involves three primary efforts: identifying HIV prevention curricula and teaching materials needed for these youth, conducting a review and critique of existing curricula and materials worldwide, and developing guidelines for state and local education agencies to use when designing or adapting HIV curricula for children and youth with cognitive, sensory, and/or motor disabilities.

For the visually disabled and impaired, AAHE will reproduce in large print its secondary and elementary student curriculum materials. To find out more about these projects, contact the HIV education staff of the Association for the Advancement of Health Education, 1900 Association Drive, Reston, VA 22091; (703) 476-3400.

Finally, HIV educators should consider the developmental levels of students to provide effective educational interventions. A helpful resource is the Developmental Profile of Children prepared by the Minnesota Department of Education (see Figure 2.2).

Figure 2.2

Educational Strategies for Health Instruction Goals

Instructional Goal	Description	Strategic Methods to Attain Goal	Example of specific impact from STD Instruction
Health Consciousness	Raising awareness	Lectures Group work Mass media Displays Exhibitions	I know that AIDS is a life-threatening disease that has no cure
Knowledge	Understanding specific information in regard to health messages	Lectures One-on-one teaching Displays Exhibitions Written materials	I know the various ways HIV is transmitted
Self-awareness/ Attitude change/ Decision making	Clarifying those values about health that are personally important to the individual	Group Work Strategies for increasing self-awareness, clarifying values, changing attitudes, and making decisions such as ranking, categorizing, role playing, or simulations	I accept that my behavior will affect my risk for contracting HIV
Behavior change	Carrying out a decision to do something about a health issue	Group Work Self-monitoring Identifying cost, benefits, and rewards Setting targets and evaluating progress Devising coping strategies Self-help groups	I am going to refrain from sexual activity until I commit myself to a mutually monogamous relationship I am going to use condoms and spermicide if I am sexually active
Social action	Changing the physical and/or social environment in order to facilitate health-enhancing behavior	All the strategies listed above plus lobbying, pressure groups, and collective health action	I am going to volunteer to work in a local hospice with PWAs I am going to participate in a peer helper program focusing on abstinence & decision making that promotes safer sex

Adapted from Ewles I., Semmett I: *Promoting Health: A Practical Guide to Health Education*. New York, John Wiley & Sons, 1985.

This profile indicates that five- to seven-year-olds value a sense of duty, accomplishment, and an acceptance of rules. Eight- to ten-year-olds, although experiencing an intensification of peer influence, take strong cues about acceptable behaviors from adult role models. A transition from parental role model to conformity to rules assigned by peer groups occurs between 11 and 13. In 14- to 16-year-olds, although there is a need for acceptance and security from parents, the intense peer group influence often results in conflict between peer and adult role models. Although the abstinence or "just say no" models used in health education curricula have been shown to be effective with elementary-aged students, those models have been minimally effective in secondary schools⁴. Adolescents often experiment with sex and drugs to rebel against authority figures such as parents, teachers, clergy, and police⁵.

The National Coalition of Advocates for Students has matched some of the major developmental characteristics of students with appropriate approaches to HIV education in its publication "Criteria for Evaluating an AIDS Curriculum." (See Appendix B.)

HIV education programs should promote a healthy self-concept.

A healthy self-concept is central to optimal well-being⁶. Health education research has indicated that students with low self-esteem are more likely to display dysfunctional behaviors⁷.

A poor self-image can be particularly counterproductive in the prevention of HIV infection. Adolescents with low self-esteem may choose to abuse alcohol or other drugs. In the case of injected drugs, users may become infected with HIV if needles are shared. Substance abuse also impairs students' judgment, increasing their chances of engaging in other risky behaviors such as unprotected sexual intercourse or promiscuous sexual behavior. Further, youth with low self-esteem are more likely to engage in premature sexual intercourse⁸.

Promoting the development of a positive self-concept is a challenge to all who work with young people. Children and youth should be encouraged to understand and accept themselves physically, emotionally, mentally, and socially.

In general, self-image may be improved by creating an environment of mutual support and caring in the classroom. Students should be given frequent positive reinforcement to nurture a strong sense of personal worth and security. Canfield and Wells offer four principles to guide teachers in creating a supportive environment:

- Accept pupil contributions without judgment.
- Maintain a "You can do it" attitude.
- Listen, listen, listen.
- Be, in all ways, a friend⁹.

Many resources are available to assist educators in promoting a healthy self-concept:

- Canfield J, Wells HC. 100 ways to enhance self concept in the classroom. Englewood Cliffs, NJ: Prentice Hall, 1976.
- Dinkmeyer D, Dinkmeyer D. DUSO (Revised) I and II: developing understanding of self and others. Circle Pines, MN: American Guidance Service, Inc., 1982.
- Dupont H, Gardner O, Brody D. Toward affective development (TAD). Circle Pines, MN: American

Guidance Service, Inc., 1974.

Johnson H. How do I love me? (2nd ed.) Salem, WI: Sheffield Publishing Company, 1986.

Nickerson C, Lollis C, Porter E. Miraculous me. Seattle, WA: Comprehensive Health Education Foundation, 1980.

Zevin D. Into adolescence: enhancing self-esteem. Santa Cruz, CA: Network Publications, 1989.

Several self-esteem videos are available, including two offered by Channing L. Bete Co., Inc., Video Communications, 200 State Road, South Deerfield, MA 01373, 1-800-628-7733. *About Self-Esteem* clarifies the role of self-esteem and its importance for good mental health and offers suggestions to help viewers assess their own level of self-esteem and think more positively about themselves. *Young People and Self-Esteem* raises teens' awareness of their own special qualities and promotes the power of positive thinking. The video includes interviews with 11- to 18-year-olds and is recommended for that age group. Another video, *Self-Esteem*, is part of a series called "The Power of Choice." The video addresses what self-esteem is, what it does for you, and how you can get it. It is available from: Live Wire Video Publishers, 3315 Sacramento Street, Santa Cruz, CA 94118, (415) 564-9500.

So that youth may develop and maintain healthy attitudes about their sexuality, educators should present sexuality in a positive manner. Discussions about sexual decision making should emphasize that abstinence is the best method of preventing pregnancy and sexually transmitted diseases, including HIV infection. Programs geared exclusively toward abstinence, however, may fail to reach the large percentage of youth who already have chosen to be sexually active. Unless abstinence program facilitators can convince sexually active adolescents that they can profitably stop having intercourse until they establish a mutually faithful monogamous relationship with an uninfected partner, the program may not have a significant impact on these youth. This task may be formidable since in 1986, it was estimated nearly half the boys and a third of the girls aged 15 to 17 in the United States were sexually active¹⁰. Insensitive promotion of abstinence may contribute to a negative self-image in sexually active students or may cause some students to discount or even ignore other information conveyed through HIV education. Those students who continue to engage in sexual activity should be empowered with knowledge and skills to prevent infection with HIV and STDs. These skills are discussed in Chapter Five.

Instructional Variables

HIV prevention programs must repeat the content sufficiently throughout the K-12 curriculum.

There is growing consensus that if HIV education is to succeed in getting youth to avoid high-risk behaviors, it must begin in elementary school. In its high-profile report, the Presidential Commission on the Human Immunodeficiency Virus Epidemic stressed that the introduction of a mandatory, comprehensive, K-12 health education curriculum is long overdue. The commission called for planned, comprehensive health education programs to put an end to issue-by-issue, stopgap measures

to correct health problems of today's youth¹¹. Including HIV-related content at each grade level of the comprehensive K-12 health program repeats prevention messages sufficiently to ensure learning.

These findings have been echoed by other high-ranking federal leaders in the fight against AIDS and HIV infection. In his report to the nation, former U.S. Surgeon General C. Everett Koop, MD, urged that HIV education begin in early grades¹².

The CDC emphasized that sufficient classroom time should be provided at each grade level to ensure that students acquire all age appropriate knowledge and have the opportunity to ask questions and discuss related issues¹³. The American School Health Association (ASHA) recommends an annual minimum of 50 hours of health instruction for students in grades K-8. High school students should have a minimum of 150 hours provided by teachers who majored in health education¹⁴. Part of this health instructional time should be devoted to HIV and other STD education.

HIV education messages should be integrated into the curricula of other subjects. Research in health education shows that broad-based interventions—in which lessons are integrated into a variety of classroom situations and repeated in multiple ways—are more likely to change sexual behavior than brief encapsulated presentations¹⁵. For example, an HIV education message of compassion toward people with AIDS and HIV infection could be taught in social studies, home economics, English, or other classes.

HIV education programs must provide quality instruction.

Quality instructional programs are marked by three characteristics: they provide appropriate content, they focus on the adoption of health-enhancing behaviors, and they are taught by qualified individuals.

Appropriate Content

Appendix A lists CDC's recommendations on critical HIV prevention content for elementary and secondary students. Specific resources containing this content are available both as prepackaged HIV education lessons developed within the context of a comprehensive health education curriculum and as free-standing lessons.

Examples of comprehensive health education models including HIV education units are:

Teenage Health Teaching Modules

Education Development Center, Inc., Suite 501
55 Chapel Street Newton, MA 02160
(800) 225-4276

In Massachusetts, call (617) 969-7100, ext. 215

Growing Healthy

NCHE Press
30 East 29th Street New York, NY 10016
(800) 225-4276

Michigan Model for Comprehensive School Health Education

Michigan Department of Education
Box 30008 Lansing, MI 48909
(517) 373-2589.

A few popular free-standing HIV education programs are: Quackenbush M, Sargent P. Teaching AIDS—a resource guide on Acquired Immune Deficiency Syndrome. Santa Cruz, CA: Network Publications, 1990.

Sroka SR. Educator's guide to AIDS and other STDs. Lakewood, OH: Stephen R. Sroka, Inc., 1987.

Yarber WL. AIDS: What young adults should know.

(Student and instructor's guide available.) Reston, VA: AAHPERD, 1987.

These three publications are available from: Network Publications, ETR Associates, P.O. Box 1830, Santa Cruz, CA 95061-1830, (800) 321-4407, FAX: (408) 438-4284.

For assistance in evaluating these and other AIDS curricula, NCAS has developed *Criteria for evaluating an AIDS curriculum* (Appendix B).

In addition, the American Foundation for AIDS Research has developed *Learning AIDS: An information resources directory*, which lists curricula as well as pamphlets, videos, and other media specific to HIV. Resources in the directory have been evaluated by an expert review panel. For information on obtaining the most recent edition, contact: R.R. Bowker, P.O. Box 762, New York, NY 10011, 1(800) 521-8110 (in New York, Alaska, and Hawaii, call collect (212) 337-6934; in Canada, call 1(800) 537-8416.)

Focus on the Adoption of Health-Enhancing Behavior

Planners must develop lessons that both educate and motivate students to adopt health-enhancing behaviors. This can be accomplished by strengthening learning activities in the cognitive (concerning knowledge), affective (concerning attitudes), and behavioral (concerning skills) domains. Quality programs are multifaceted. They provide instructional activities to increase students' awareness about HIV and to promote responsible decision making and attitudinal change. Perhaps most importantly, quality programs succeed in motivating students to avoid high-risk behaviors and to participate in social actions that reinforce proper behaviors.

Figure 2.3 lists specific educational strategies for achieving health instruction goals in the cognitive, affective, and behavioral domains¹⁶.

This schematic illustrates a range of instructional goals, from raising consciousness and increasing knowledge to behavior change and social action. The former pair are fundamental to making decisions in the context of personal behavior management and social action. Beyond arming students with accurate knowledge about HIV, educators should help them learn how to make responsible decisions and follow through with health-enhancing behaviors. Lessons also should develop refusal, decision-making, and communication skills; assertiveness; positive self-esteem; and mechanisms for coping with peer pressure. Use of these skills empower students to carry out their decisions to either maintain positive health behaviors or to reduce or eliminate unhealthy behaviors. Health-enhancing HIV-related behaviors include abstinence from sexual intercourse and drug and alcohol use; by clouding judgement, drugs and alcohol may lead to risk behaviors for HIV infection. Those who are unwilling to refrain from such behaviors should use a latex condom with spermicide containing nonoxynol-9

during sexual intercourse, limit the number of sexual partners, and not share needles or other drug equipment.

The adoption of health-enhancing behaviors can be reinforced through instructional activities promoting social action. Students committed to the prevention of HIV infection may be encouraged to reach out to their peers and to society in many positive ways. Students who are knowledgeable about HIV prevention could organize and staff a local AIDS hotline for teens. They also may participate in HIV infection prevention programs in the community, such as volunteering at local hospices, being a "buddy" to a person with AIDS, organizing or participating in a theater group that addresses HIV infection prevention, designing a panel for the "NAMES Project" AIDS quilt, or raising money to assist children with AIDS. Student social action should be reinforced by parents, teachers, and other adults. Adults can be supportive of adolescents' decisions to participate in HIV-related causes in the community and may also choose to join them in working for such causes.

Qualified Teachers

Presently, a variety of school-based professionals are teaching about HIV infection. As is the case for sexuality education, teachers of health and physical education, home economics, and science, as well as the school nurse, are taking leadership positions in HIV education. CDC recommends that HIV education be conducted within an already established comprehensive school health program. The health educator should take an active role in HIV education. However, reinforcing messages should be supplied by a variety of school-based professionals as well as by parents.

According to Haffner, educators qualified to teach about HIV should demonstrate the following qualities:

- A willingness and interest in teaching HIV education.
- Genuine appreciation and respect for adolescents.
- Basic knowledge about HIV, its transmission and its prevention.
- Familiarity and comfort with sexual terminology and sexual issues.
- Respect and support for a diversity of student and family values.
- Effective communication and teaching skills¹⁷.

For teachers to exhibit the characteristics described by Haffner, there appears to be considerable need for in-service education. According to results of a national survey of educators, administrators, nurses, counselors, physicians, school board members, and high school parent/teacher association presidents conducted by the ASHA, 54% needed information on how to promote or plan school health education programs to prevent the spread of HIV. Fifty-seven percent needed information on integrating school-based HIV education programs with community health, religious, and youth agencies. Some 42% needed assistance in evaluating HIV education materials. Over half of the respondents needed updated information regarding homosexuality, bisexuality, STDs, risk behaviors for HIV transmission, IV drug use, death and dying, safer sex practices, and communicating about HIV with a sexual partner¹⁸. These topics should be addressed during in-service programs to enhance the ability of school-based professionals to teach about HIV.

Environmental Variables

HIV education programs should involve parents and families as partners in the instructional experience.

Research on the effect of family values and behaviors upon children's decision-making and actions demonstrate the importance of parental and sibling involvement in HIV education. Children raised in an environment where questions and dialogue are encouraged seek information from parents more often than those who feel such freedoms do not exist in their homes. Children from homes with good communicators are more likely to follow the positive role models their parents provide and seek family direction for and approval of their behavioral choices. Parents should encourage their children to share experiences in an atmosphere of acceptance and trust. To enhance their role in HIV prevention, parents must know the basic facts about the virus, as well as be aware of issues and decisions confronting today's youth.

Schools could teach parents about HIV infection and AIDS through a parent information night or newsletters. This outreach to parents should include a parent/student communication component, which encourages two-way dialogue and instruction. One example of parent outreach is the Parent-Teen AIDS Education Program, developed by the San Francisco AIDS Foundation. The program includes an implementation manual, video, brochures for parents, and parent meeting guides. Its goals are to provide parents with the facts about AIDS, to motivate them to discuss the disease with their teenagers, to help teens and parents respond compassionately to people infected with and affected by HIV, and to encourage parental advocacy for HIV education in the schools¹⁹. For information, contact: The San Francisco AIDS Foundation, 333 Valencia Street, Fourth Floor, P.O. Box 6182, San Francisco, CA 94101-6182, (415) 861-3397.

HIV education programs should use adult and student interaction in the classroom setting to reinforce formal or informal HIV infection prevention or education messages.

As already stated, the classroom provides both formal instruction and incidental learning. Knowing that youth are more influenced by the actions of adults than by their words, educators should take advantage of the strong effect of informal modeling. Youth care about adult acceptance of their choices and behaviors. Youngsters are likely to imitate the health-related habits of adults, whether positive or negative.

Many potential role models exist: community leaders, clergy, teachers, coaches, sports figures, radio and television personalities, older siblings, and others. Needed as positive role models are persons who are knowledgeable about HIV and AIDS and who attempt to dispel HIV-related myths. Such persons should treat PWAs with compassion and concern and deplore discrimination against these individuals. They should act in responsible ways with regard to sexuality and refrain from illicit drug use. Educators can identify and make examples of these positive role models.

HIV education programs should use students as active partners in the instructional process.

Peer influence and modeling is evident in the society of youth. Children are likely to get involved with others who demonstrate attitudes and behaviors like their own or alter theirs to fit into a group that they deem desirable. Studies have indicated that having a friend who engages in

premarital intercourse is the most powerful predictor of an individual's likelihood to have premarital sex²⁰. Involving students in the delivery of education and counseling programs is important and will be addressed in depth in Chapter Four.

HIV education programs should counter sexually irresponsible mass media messages and reinforce more responsible messages.

Figure 2.3

Developmental Profile of Children, Ages 5 - 19

Developmental Characteristics of Children and Youth

AGE	PHYSICAL	COGNITIVE	SOCIAL
5-7 YEARS	- girls ahead of boys in physical development and achievement - small muscle and eye-hand coordination developing - increasingly skillful with tools & materials - masters physical skills necessary for game playing - high energy level - physical skills important in influencing status with peers	- differentiates clearly between fantasy and reality - attention span by age 7 shows dramatic lengthening — has ability to shift attention - concepts are largely functional - can order objects on dimensions of size and quantity - memory good for concrete sequences (numbers) - is able to give more thought to judgments and decisions	- beginnings of empathy; sees others point of view - two or three best friends - play groups are small and of short duration - quarrels frequent, but short - beginning of conformity with peers (dress, language) - peers become increasingly important - beginning of sex cleavage; less boy-girl interaction
8-10 YEARS	- physical skills are gaining more importance influencing status with peers and self-concept - girls ahead of boys in physical development, taller, stronger, more skillful in small muscle coordination - high energy level - is able to take responsibility for personal hygiene - girls begin growth spurt toward end of this group - quiescent growth period for boys	- capable of prolonged interest - see similarities - can apply logical thought to practical situations - beginning to understand relationship of cause and effect - understands concept of money - understands concept of time; has ability to plan ahead	- intensification of peer group influence - cliques of the same sex - both boys and girls interested in hobbies - competition more common, with considerable boasting - overly concerned with peer imposed rules - antagonism between boys and girls leads to frequent quarrels - extreme energy expenditure in physical game playing
11-13 YEARS	- boys begin growth spurt - adolescent growth spurt at peak for girls, with changes in body proportions - pubescent stage for girls; secondary sex characteristics continue to develop, breasts develop, menstruation begins - improved motor development & coordination, especially in boys, who excel in physical achievement	- transition from concrete to abstract thinking; uses abstract words - emergence of independent critical thinking - can apply logic to solve problems; thinks inductively - can solve problems by considering alternatives	- peers become source of behavior standards and models - conforms to rules assigned by group - team games popular - crushes and hero worship are common for same and opposite sex - boisterous behavior common - self-consciousness creates anxiety about behavior - faced with decisions regarding alcohol and drug use
14-16 YEARS	- adolescent growth spurt at peak for boys, with changes in body proportions - pubescent stage for boys; secondary sex characteristics continue to develop	- makes fine conceptual distinctions - concerned with the hypothetical, the future, and the remote - formulates and tests hypothesis to consider all the possible ways a problem can be solved; deals with logical and imaginary solutions - aspirations frequently exceed capabilities - uses abstract rules to solve problems	- preoccupation with acceptance by social group - boys and girls have a few close friends of both sexes, friendships last longer - peer group influence is intense - increase in conflict between peer and adult roles - primary groups continue to be same sex, but there is more heterosexual interaction - girls more socially adept than boys
17-19 YEARS	full physical development for both boys and girls	- continues to refine language and thinking abilities - increased life experiences provide more and new opportunities for refinement of previously learned reasoning-thinking skills	- choice and opinion reflect continuing peer influence - group activities provide an outlet for expressing feelings - looking for permanence in heterosexual relationships - move to living full time with peers (college); new interpersonal satisfactions and problems

References: Association for Supervision and Curriculum Development *Developmental Characteristics of Children and Youth*, 1975.
Human Growth and Development Throughout Life: A Nursing Perspective, 1982.

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 Learner Support Systems Minnesota Department of Education

The powerful and persuasive impact of television on youngsters is unquestionable. Television's primary impact on learning is related to viewing time. Walberg found that, generally, the more time students spend watching TV, the less time they devote to learning¹. On average, teenagers view 24 hours of television per week and youth aged 12 to 17 listen to the radio approximately 18.5 hours weekly²¹.

Television also can provide an unrealistic view of sexuality in our society. Sexual content on TV programs

is pervasive, but there is little reference to sex education, STDs, unwanted pregnancies, or contraceptives²¹. Louis Harris and Associates have estimated that for every 85 instances of sexual content, there was only one counterbalancing reference to more responsible aspects of sex such as the use of contraceptives or the prevention of sexually transmitted disease²².

Further, the Center for Population Options reports there are approximately 20,000 scenes of suggested sexual

SELF	VALUES	SEXUALITY
- clarifies differences between adult and self - achieves independence in physical self care - gaining practical knowledge necessary for everyday living - exploration is more goal directed - learning to forego immediate reward for delayed gratification	- sense of duty and accomplishment - developing consciousness is in evidence; resulting behavior may be rigid and expressed in extremes - beginning to accept there are rules, but does not understand the principles behind them	- strong interest in origin of babies - aware of sex differences - plays doctor - tends to be modest in front of opposite sex - name calling includes words dealing with elimination
- conforms to sex role - achieving personal independence - aware of importance of belonging - self-sufficient, can do things independently inside and outside the home	- testing and questioning attitudes, values, belief systems; may result in conflict - adult role models give strong clues about acceptable behaviors - understands the reason for rules and behaves according to them - beginning to make value judgements about own behavior, set standards for self, accept responsibility for behavior	- wants more exact information - peers share sexual information and misinformation - most know about sexual intercourse - interest in sexual jokes - is sexually modest - expresses disinterest of opposite sex
- achieves a masculine or feminine social role - learning one's role in heterosexual relationships - seeking self-identity sometimes includes rebellion - self-concept is influenced by bodily changes	- asserting and developing own value system although peer influence is strong - understands ethical abstractions (example: justice, honesty) - beginning to be aware of and discuss social issues	- aware that intercourse occurs apart from conception - ones' sex role is a concern - information from peers is actively sought - interests in opposite sex, although girls are more interested in boys than boys in girls - girls are absorbed in their own body changes - frequent erections occur in boys
- competitive peer relations produce some distrust - confides more in friends than parents - worries about physical appearance, attractiveness and physical appearance - assurance of acceptance and security of parents is still necessary	- interest in philosophical, ethical and religious problems - is aware of and verbalizes contradictions in moral code - group beliefs important in influencing values	- intimate and casual heterosexual activity and experimentation occur - homosexual activity and experimentation occurs
- worries about career choice and other aspects of the future - anxious about formation and continuation of intimate heterosexual relationships	- integrating values into a personal philosophy including ethical and moral standards to be used in adult life - is able to make personal commitment	- many boys and girls have had intimate sexual activity - both boys and girls are struggling to learn socially approved outlets for sexual arousal

intercourse and behavior, sexual comments, and sexual innuendo in a year of prime-time television. Messages of infidelity seem to overshadow those of fidelity. Television portrays six times more extramarital sex than sex between spouses, and 94% of sexual encounters on soap operas are between people not married to each other²³.

The HIV crisis has awakened some to the need for the media to shoulder its responsibility in addressing current health concerns, but response has been slow and incomplete. With its powerful influence, the media has great potential to reinforce HIV prevention efforts. Educational programs and documentaries can provide direct education. Fictional story lines in television series, movies, and other programs can convey prevention messages that also evoke compassion for those affected by HIV.

HIV educators and other school-based professionals can reinforce positive media messages by assigning students to watch educational programs and documentaries. To counter negative media messages, students may be assigned to critically view television programs (e.g., soap operas and music video programs) to determine the incidence of irresponsible sexuality that is portrayed on such programs. Classes can discuss how these story lines could be adapted to promote more responsible sexual behavior. Students may follow this activity by writing to national and local television networks to encourage the provision of responsible messages regarding sexual behaviors and HIV prevention practices. The following are the addresses of major television networks:

American Broadcasting Company (ABC)

1330 Avenue of the Americas

New York, NY 10019

Columbia Broadcasting Company (CBS)

51 West 52nd Street

New York, NY 10019

Fox Broadcasting Company

10201 West Pico Boulevard

Los Angeles, CA 90035

National Broadcasting Company (NBC)

30 Rockefeller Plaza

New York, NY 10112

Another powerful medium, music, could be used in the prevention of HIV infection. Although some artists have committed their careers to providing responsible messages to youth through music, others have not. Unfortunately, lyrics of many popular songs seem to reinforce irresponsible health-related behavior choices. Educators should explore ways to counteract these negative messages and use music as a positive force in the classroom. For example, they could play examples of popular songs in the classroom and discuss with students the negative or positive messages of these songs. This exercise would help increase student awareness of music's impact and influence on our society and further develop their critical thinking skills.

HIV prevention programs should develop strategies that raise students' awareness of the risk of HIV infection.

The more individuals perceive a personal risk of contracting a disease, the more likely they are to engage in behavior to prevent it²⁴. Studies have demonstrated that homosexual or bisexual males and IV drug users who

previously engaged in behaviors that put them at risk for HIV transmission have made significant changes and modifications in these behaviors as they perceived a personal threat of becoming infected²⁵.

Unfortunately, behavior change among adolescents has not occurred at a similar rate^{25,26}. Most youth do not perceive AIDS and HIV infection as a personal threat. In a study of 250 Ohio youth, 73% indicated they were not worried about contracting HIV²⁷. In Massachusetts, 61% of 892 randomly selected adolescents did not believe it likely they would acquire HIV²⁶. In San Francisco, 79% of adolescents expressed fear of getting HIV/AIDS. But 53% also felt they were less likely than most people to contract the disease²⁸. Educators should implement programs that appropriately increase the acknowledgment of personal risk among those whose behavior may lead to HIV infection while reducing unnecessary fear among those who are not at risk. Most teens' feelings of invulnerability make this a difficult task.

A most effective method to impress upon teens that they are vulnerable to HIV infection is to have a young adult guest speaker with HIV infection or AIDS address the class. The local AIDS Task Force or state and local health departments sometimes have a speakers' bureau that will provide speakers for such programs. If a teen speaker is not available, several videos have been developed that feature teens with AIDS or HIV infection. Examples of these include:

AIDS-Wise, No Lies features ten young people whose lives are affected by AIDS. Their stories break through the barrier of youthful invulnerability and empower viewers with a sense of choice and control over their own behaviors and the risk of contracting HIV. Contact: New Day Films, 853 Broadway, Suite 1210, New York, NY 10003, (212) 477-4604.

AIDS or Eighty Something is designed to impress upon teen audiences that they are vulnerable to AIDS and HIV infection. It emphasizes to teens that they can live normal and healthy lives if they understand how HIV is transmitted and take measures to protect themselves from infection. There are two versions of this program: one contains line drawings of how a condom is put on, the other does not. Purchasers can specify which version they would like. Contact: NEWIST/CESA #7, IS 1110, University of Wisconsin, Green Bay, WI 54311, (414) 465-2599.

Teen AIDS in Focus is about three young people with HIV infection. They talk openly about how it has affected their lives, futures, and relationships. This video is targeted to youth aged 13 to 21. Contact: TEEN AIDS/S.F. Study Center, P.O. Box 5646, San Francisco, CA 94101, (415) 626-1650.

These videos were designed to help to make the threat of HIV infection real to teenagers. When this information is combined with sound instruction about behaviors that place one at risk and about prevention practices, students are empowered with knowledge about how to avoid HIV infection. Those who are not practicing risk behaviors learn that they are not vulnerable to HIV infection. Skills and practice exercises that will enable students to make healthful decisions, refuse unwanted sexual and drug use advances, assert themselves, and communicate effectively to prevent HIV infection are included in Chapter Five.

HIV prevention programs should emphasize the risk of other STDs.

Adolescents should be made aware that each act of unprotected sexual intercourse potentially exposes them to any of a large number of sexually transmitted diseases, some of which have no cure. Students should be able to recognize the signs and symptoms of STDs. Information and pamphlets which describe various STDs, their signs, symptoms, and treatment are available from the National STD Hotline at 1-800-227-8922.

If consistent with local standards, classroom discussion of appropriate responses to finding one has been infected with an STD (e.g., visiting the health care provider, informing sexual partners of a positive test, and following the instructions of the health care provider) versus inappropriate responses (e.g., not going for treatment when symptoms appear, not informing all sexual partners) should take place. In addition, all students, even those not currently sexually active, should be taught about prevention practices such as using latex condoms with a spermicide.

HIV prevention programs should include strategies to provide access to health services as needed and foster positive attitudes about health care.

Public health officials traditionally have not provided primary health care services in the schools, assuming that it was the schools' responsibility to provide health promotion and some health services needs. School officials, in turn, have viewed the provision of primary health services as the responsibility of parents. Many parents pay little attention to their child's health needs when the child is healthy, but during illness, the parents look to the health sector. Thus, the cycle of transferred responsibility continues²⁹.

This cycle can be broken if health and education officials begin to work collaboratively to provide comprehensive primary health care. Numerous strategies have proven effective: 1) school-based primary health care, 2) school-linked primary health care, and 3) referral to existing community services. School-based primary health care clinics have the added benefit of increasing student access to health care. All of these strategies offer a range of preventive and therapeutic health care interventions addressing mental, emotional, and physical health. Assistance in creating a school-based clinic can be obtained from:

Support Center for School-Based Clinics
1025 Vermont Avenue, NW, Suite 210
Washington, D.C. 20005
(202) 347-5700

Regardless of the strategy employed to provide students access to health services, positive attitudes about health care need to be fostered. Specifically, health care providers need to demonstrate qualities similar to those of educators:

- Genuine appreciation and respect for adolescents.
- Respect and support for a diversity of student and family values.
- Familiarity and comfort with sexual terminology and sexual issues.
- An interest in initiating instruction of reproductive health, including HIV, its transmission, and its prevention.¹⁷

Incorporating the above characteristics should increase the comfort level of students and subsequently increase their participation in clinic activities. According to the Robert Wood Johnson Foundation, positive attitudes toward health care services may be enhanced by hiring health care providers who have a caring attitude toward, and genuine liking for teens. A relaxed, nonthreatening tone needs to be set by the intake person or receptionist in particular. To minimize stress and the stigma associated with attending the clinic, adolescent health care specialists may choose to adapt an informal style by eliminating white uniforms and working on a mutual first-name basis. All clinics should provide privacy and ensure confidentiality. Provision of separate entrances and waiting rooms for adolescents is recommended for school-linked clinics, since adolescents are reluctant to use a facility where they may have an unexpected encounter with family members or neighbors. Appropriate and accessible hours of operation and short waiting periods at the clinic are also important to adolescents³⁰.

HIV prevention programs should provide appropriate interventions for populations at greater risk.

Sex/Age/Developmental Level

AIDS occurs more frequently in certain segments of the population. Males represent a greater proportion of current cases than females. Though few adolescents have been diagnosed with AIDS, about one-fifth of all persons diagnosed with AIDS are in their twenties. Because the incubation period between HIV infection and AIDS diagnosis is believed to be about 10 years, many persons with AIDS aged 20 to 29 probably contracted the virus in their teens.

Irwin and Millstein have stated that being out of step with peers may be a predisposing factor that places certain adolescents at risk for health-compromising behaviors. The timing of biological maturation directly influences cognitive scope, self-perceptions, perceptions of the social environment, and personal values. In turn, these factors are influenced by the individual's perception of risk and peer group characteristics. Risk taking in middle and late adolescence may fulfill developmental needs related to autonomy, mastery, and individuality⁸.

Early-maturing females in general appear more ectomorphic, exhibit more dissatisfaction with their physical appearance, have lower self-esteem, show less success in academic and intellectual endeavors, and have a greater prevalence of problem behavior than their age peers⁸.

Late-maturing males in general appear more ectomorphic—a less socially valued body type—have more dissatisfaction with their body type, have a negative self-concept, have a greater frequency of major identity crises, and are described as more rebellious and impulsive than their age peers⁸. The bio-psychological factors correlated with premature sexual activity are displayed in Figure 2.4.

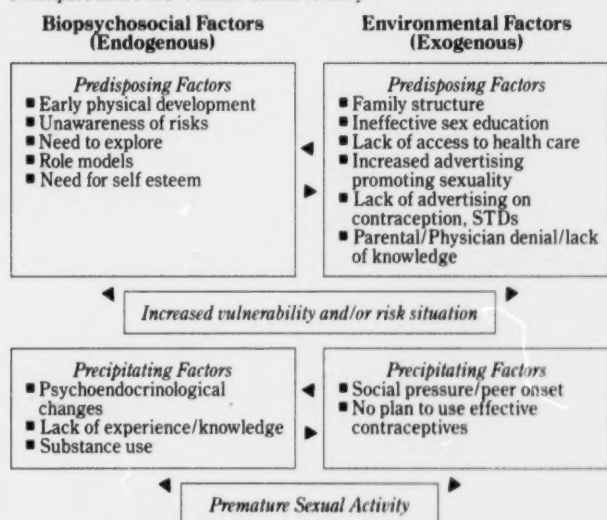
Ethnicity

Minorities, particularly blacks and Hispanics, account for a disproportionate percentage of newly diagnosed

cases of AIDS. The rate of AIDS cases among blacks and Hispanics is about three times the rate for the total population. Blacks make up about 12% of the U.S. population, yet approximately 28% of reported U.S. AIDS cases are among black Americans. Hispanics make up about 7% of the U.S. population and over 15% of U.S. AIDS cases³¹. Furthermore, 52% of all women in the United States with AIDS are black and nearly 20% are Hispanic. Among children under 13 years of age, 54% of the AIDS cases are among blacks and 26% are among Hispanics. The disproportionate prevalence of AIDS and HIV infection among blacks and Hispanics has been attributed to high rates of injected drug abuse. Other minorities in the United States, such as Native Americans, Asians, and Pacific Islanders, have a much smaller cumulative incidence of AIDS^{31,32}.

Figure 2.4

Principal Factors in Premature Sexual Activity



Adapted and reprinted with permission of Elsevier Science Publishing Co., Inc. from "Biopsychosocial Correlates of Risk-Taking Behaviors During Adolescence", by Irwin and Millstein, *JOURNAL OF ADOLESCENT HEALTH CARE*, Vol. No 7 (6S) pp. 90S, Copyright 1986 by The Society for Adolescent Medicine.

To enhance effectiveness, educational interventions should address and attempt to reduce potential barriers to reaching minorities. Culturally sensitive educational strategies should acknowledge contributing factors such as unemployment and inadequate education. Language barriers should be addressed, as should cultural norms and customs. Media interventions should consider sociocultural preferences when preparing public service announcements for particular print media and radio stations.

Minorities have also been shown to have more misconceptions about the transmission of HIV than their white counterparts³³. These misconceptions need to be corrected. Finally, an increased sense of personal vulnerability combined with a heightened suspicion of "government" and its officials is a barrier that needs to be considered when designing educational interventions for minorities³⁴.

Culturally sensitive educational materials have been developed such as *The Latino Family Life Education Curriculum Series* for Latino students in grades 5-8. It is available from Network Publications, ETR Associates, P.O. Box 1830, Santa Cruz, CA 95061-1830, (800) 321-4407 or FAX (408) 438-4284.

A videotape that addresses the Latino community in a soap opera or "novella" format is: *Face to Face with AIDS*. Contact: Select Media, Inc., Educational Film and Video, 74 Varick Street, Suite 305, New York, NY 10013, (212) 431-8923.

A videotape that targets black and urban youth is available from local chapters of the American Red Cross. The 30-minute video, entitled *Don't Forget Sherrie*, features Michael Warren from the TV series "Hill Street Blues" and former U.S. Surgeon General C. Everett Koop. In addition, the American Red Cross has a HIV/AIDS Instructor Course, an HIV/AIDS African American Program, and an HIV/AIDS Hispanic Program. Each of these programs can lead to instructor certification. Contact the local chapter of the American Red Cross to find out more about these programs and HIV/AIDS materials available for use with educators, parents, and youth.

Out-of-School Youth

Research indicates that segments of the out-of-school youth population are at a much greater risk for HIV infection than youth who stay in school³⁵. Although the drop-out rate of students nationally has been estimated at 25%, the rate is much higher in urban areas. Other out-of-school youth particularly at risk for HIV infection include those in juvenile detention programs, teen runaways, and teens engaged in prostitution. A 1988 study of a convenience sample of 1,111 homeless and runaway youth that was conducted by Covenant House in New York City found 7% of those aged 16 to 21 and 17% of the 21-year-olds to be infected with HIV³⁵.

According to the National Network of Runaway and Youth Services (NNRYS), barriers to providing HIV education for these youth are formidable. Out-of-school youth are disconnected from families and other social support systems. Many report alarming rates of alcoholism, neglect, and physical and sexual abuse by their parents. They are in pain and crisis, which clouds their ability to think and reason. Much of their information comes from peers and the media. This type of information, even if it is accurate, provides little opportunity for adolescents to develop the skills necessary for HIV infection prevention³⁶.

In addition, much of the information available to these youth is judgmental, stigmatizing, and beyond their comprehension. Many of them are involved in prostitution, which may be better termed "survival sex" since many who participate in it do so in order to survive (get money for food, shelter, clothing, etc.), and drug use which makes them even more difficult to reach. Finally, experts who work with these youth report that their denial is strong and thoughts of the future are few. These youth live for the present, and the majority think that AIDS is a disease that others acquire³⁶.

The NNRYS suggests several strategies for youth workers to use in responding to the needs of runaway and homeless youth:

- Reconnect youth to their families whenever possible.

- Speak with awareness of these youths' physical and emotional states and in a language that they understand.
- Provide current, scientific information in multiple sessions.
- Present human sexuality as a positive force and emphasize sexual responsibility.
- Help those who are infected with HIV cope with psychosocial issues surrounding the infection.
- Come to terms with your own HIV-related issues and personalize AIDS issues for the youth whom you are attempting to help.
- Channel your anger in constructive ways to assist youth.
- Empathize with these youth by putting yourself in their shoes: be sensitive and compassionate; give them hope³⁶.

Educational materials and information specific to youth in runaway shelters or detention centers can be obtained from:

The National Network of Runaway and Youth Services
SAFE Choices Project
1400 I Street, N.W.
Washington, D.C. 20005

and:

The National Commission on Correctional Health Care
AIDS Program Director
2000 North Racine
Chicago, IL 60614

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Chapter 3:

HIV Prevention Strategies for School and Community

HIV education should not be instituted as a special subject. Ideally, it should be part of a comprehensive K through grade 12 health education course of study. According to the major health education professional associations, the school health instructional program should possess these nine characteristics:

- 1) A planned, sequential, K through grade 12 curriculum based on students' needs, on current and emerging health concepts, and on societal issues.
- 2) Instruction intended to motivate health maintenance and promote wellness, not merely the prevention of disease or disability.
- 3) Activities designed to develop decision-making competence related to health and health behavior.
- 4) Opportunities for all students to develop and demonstrate health-related knowledge, attitudes, and practices.
- 5) Integration of the physical, mental, emotional, and social dimensions of health as the basis for study in 10 topic areas: community health, consumer health, environmental health, family life, growth and development, nutritional health, personal health, prevention and control of disease and disorders, safety and accident prevention, and substance use and abuse.
- 6) Specific program goals and objectives.
- 7) Formative and summative evaluation procedures.
- 8) An effective management system.
- 9) Sufficient resources such as budgeted instructional materials, time, management, staff, and teachers.¹

Although providing students with a K through grade 12 comprehensive health education course of study that includes the elements of HIV prevention is fundamental, it is not sufficient by itself to ensure the adoption of health-enhancing behaviors. The formal health education curriculum should be reinforced with other effective health promotion strategies: policy mandates, health services, social support, role modeling, and media presentations. Further, supplemental HIV instruction should be

- 1) integrated into lessons in multiple curricular areas,
- 2) provided in school club and activity programs,
- 3) coordinated with parental instruction, and 4) promoted through community health programming.

Students learn best when consistent messages are provided through multiple channels. Such consistency requires the participation of teachers, administrators, school nurses, counselors, school boards, parent-teacher associations (PTAs), parents, and community workers. A multidisciplinary team of special service providers (nurses,

physicians, psychologists, and counselors) unites the instructional expertise of educators with expertise in behavioral management techniques, human relations, and learning and development². To complement this professional expertise, the support of parents and peers is critical to the adoption of health-enhancing behaviors.

Developing a multidisciplinary, multi-intervention approach to school and community HIV infection prevention can be accomplished through the development of an interdisciplinary school health team that interfaces with a school-community interagency network. Successful multidisciplinary HIV prevention programs require a broad-based commitment, careful planning, and effective implementation. However, this type of effort can be initiated in any school. It does not require additional staff or a large budget. By following the principles of program planning, a comprehensive approach to HIV prevention can be accomplished. As depicted in Figure 3.1, there are six basic steps:

- involving people
- setting goals
- defining the problem from a local perspective
- identifying strategies to be used in the action plan
- implementing the plan
- evaluating results.³

Involving People

The first step requires bringing together the different and influential groups that make up the constituents of the school and the community. The ideal approach to HIV prevention links professionals within the school as well as integrates the school activities with those of the community. School-based professionals, such as teachers, nurses, counselors, psychologists, and administrators, can work with parents and students to devise a multi-faceted program that is delivered through both curricular and extra-curricular efforts. The work of the school health team is enhanced if the community has mounted a similar campaign to prevent the spread of HIV infection.

Community programming may involve the following: public health officials; representatives from social services, and from legal, recreational, religious, and voluntary health organizations; agencies that serve youth; and staff members from area hospitals, health clinics, and hospices who deal with HIV infection. Parents; professionals, such as private

health practitioners, counselors, psychologists; and those who serve high-risk youth such as runaways, school dropouts, and drug users seeking treatment, should also be represented in a communitywide plan to prevent the spread of HIV.

Broad-based involvement in all stages of planning for a health promotion program is essential. Gaining approval and resources from the school administration, for example, may be facilitated if an administrator actively participates in the process, if there is broad support from parents and external

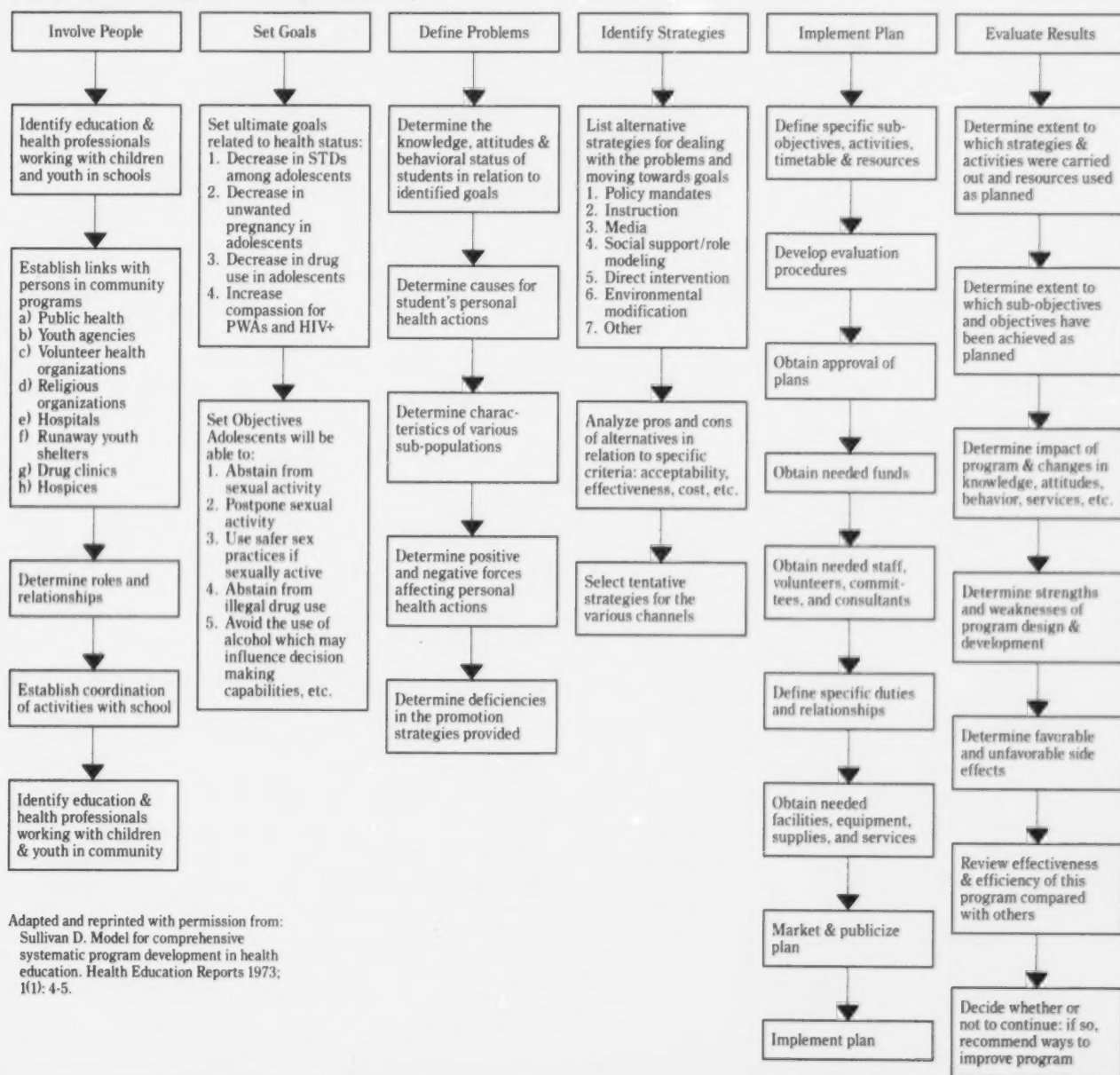
professionals, and if funds for administering the program are generated externally by a school/community interagency network. Student and staff acceptance also is enhanced by involving them in the planning stages.

School Health Committee

Within the school, a school health committee is often formed to promote the health instruction and service needs of the students. Membership of this committee should include the principal, health education coordinator, school

Figure 3.1

Steps in Program Planning to Prevent the Spread of HIV Infection



nurse, counselor, psychologist, food service director, physical educator, PTA president, teachers of other subjects concerned with health (such as home economics, biology, and science), and students. This committee, which oversees all health concerns, would be ideal to take the lead in developing programs to prevent HIV infection. Someone from this committee should serve as a liaison to a communitywide campaign with the same purpose, prevention of HIV infection.

School-Community Collaboration

Four types of organizational efforts, differentiated by purpose and structure, may be used to involve people through the organization of a school-community response to reduce the spread of HIV infection:

Task Force: Generally a subgroup of an existing organization, this temporary unit organizes under one leader for the purpose of accomplishing a specific objective.

School Health Advisory Council: This group primarily comprises individuals outside the education profession. Members are selected from various segments of the community to collectively advise school administrators about the health education program¹. Advisory councils may provide advice and make recommendations, but they have no legal authority and their advice may be ignored.

Interagency Network: This structure establishes links among community agencies to exchange, barter, or create information and services. The structure of interagency networks varies. Some may be informal groups organized only to exchange information on respective programs. Others have highly structured linkages in which member agencies pool resources to achieve common goals.

Coalition: This alliance of diverse individuals and groups organizes to take joint action on a shared issue or concern². Coalitions sometimes are viewed as a form of an interagency network. Like other interagency collaborations, coalitions use consensus decision-making, shared governance, parity among members, and collegiality. Authority as well as resources are shared. The following is a list of resources that may be helpful to those interested in developing one of these various structures.

1. Allensworth DD. *Building effective coalitions to prevent the spread of HIV: planning considerations*. Kent, OH: American School Health Association, In Press.
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Although all of these organizational structures can be used to coordinate a communitywide educational response to AIDS and HIV infection, a coalition or interagency network has the most autonomy and chance for continued success. More important than the structure or name of the coordinated effort, however, is the active involvement of all interested and affected organizations. Following a program planning model facilitates the attainment of specific goals as the combined resources of the organizations focus on eliminating the problem.

Setting Goals

Simply stated, the primary goal of a coordinated, communitywide effort is to reduce the incidence of HIV infection. Other related goals also may be targeted, such as reducing the incidence of all STDs, teen pregnancy, and/or illegal drug use. In a report prepared for the Sex Information and Education Council of the United States, Debra Haffner suggests that the following behavior-based goals be adopted as goals of an HIV prevention program:

- Decrease the misinformation about HIV, thus reducing the panic associated with the disease.
- Delay premature sexual intercourse among young people.
- Increase the information and services to sexually active young people to encourage the use of condoms each and every time they have intercourse.
- Increase the warning about the dangers of drug use in all HIV education programs.
- Increase compassion for people with AIDS as well as those with HIV infection.⁶

To attain any broad goal, specific objectives must be developed. For example, if the goal is to decrease the incidence of HIV infection in the adolescent population, specific objectives that will facilitate this outcome must be formulated. Samples of such objectives follow:

- 80% of the student population will abstain from sexual intercourse until marriage.
- The remaining 20% of the student population will postpone sexual intercourse until they reach their twenties.
- All sexually active students will use risk reduction practices.
- At least 75% of students will abstain from marijuana and alcohol use.
- All students will abstain from injecting illegal drugs including steroids.
- All students will avoid sharing needles and other blood-mixing activities.

These objectives may be broken down into subobjectives. For example, if the objective was to abstain from sexual activity, the subobjectives might be as follows:

By the end of the semester, the students will be able to:

- Describe puberty, male and female anatomy, physiology, and human reproduction.
- Discuss the issues associated with being sexually active as an adolescent.
- Compare and contrast the costs (physical, emotional, social, intellectual, economic) of becoming a parent at age 15 with becoming a parent at age 25.
- Analyze the immediate and long-term costs of contracting an STD.

- Use a decision-making process to clarify personal goals, values, and aspirations regarding one's sexual, social, and occupational desires.
- Practice refusal and decision-making skills to postpone sexual activity.

Setting the goals and objectives provides the focus for programming. Objectives should be realistic, developmentally appropriate, and placed in order of priority to ensure that resources are directed towards the goal(s) deemed most important.

Defining the Problem from a Local Perspective

Before tackling the goal of reducing the incidence of HIV infection among youth, one must identify and assess the knowledge, attitudes, and behaviors of students as well as the existing services within the school and community. To aid in this analysis, the following questions should be answered:

- What are the present HIV knowledge levels and attitudes?
- What risk behaviors for HIV infection are prevalent within this population?
- What are the underlying motivations for these risk behaviors?
- What variations exist in the knowledge, attitudes, and behaviors among various subgroups?
- What are the positive and negative forces affecting personal health actions to prevent the spread of HIV?
- What resources and health promotion strategies currently exist, and what additional ones are needed to attain the goals?
- What reproductive health services (STD testing, access to contraceptives, counseling, etc.) are available?
- What are the knowledge, attitudes, and behaviors of health professionals in regard to providing services to students to prevent the spread of HIV?
- What are the attitudes and behaviors of family, peers, and health care providers? Do they promote HIV risk-reduction behaviors?

The focus of this process is to compare the real with the ideal. By defining the problem from a local perspective, planners are able to compare existing circumstances with desired outcomes. Anonymous data for this process can be obtained from 1) students, parents, educators or health care workers via questionnaires or interviews, 2) statistics from public health records (incidence of STDs, teen pregnancies), 3) statistics from police records (drug arrests, etc.), 4) clinics or hospitals that treat adolescents, or 5) agencies, clubs, or organizations that provide educational programs or services.

Identifying Strategies

A strategy is a plan or method to achieve a goal. The following strategies may be used to prevent the spread of HIV infection: policy mandates, instruction, media, social support/role modeling, direct intervention, and environmental or facility modification.

Policy Mandates: A policy is a statement of action selected from alternatives to guide and determine present and future decisions. Policy statements may be used by administrators not only to convey commitment but to direct the actions of others within the system. Policy mandates command that attention be focused on a problem.

Most school districts have developed policies that address issues such as integrating a person with HIV infection (student or staff) into the school program, managing inappropriate fear and even panic, protecting the confidentiality of individuals with HIV, and providing HIV instruction as part of a comprehensive, K through grade 12 health education program.

School districts may also wish to develop policies that facilitate the multidisciplinary approach to HIV education discussed throughout this manual. For example, the school board may write and adopt a policy that mandates that all school-based personnel (both instructional and support staff) as well as parents and the community become involved in HIV infection prevention programs. Obviously, all of these persons would not be involved in the instructional program. School support personnel may be required to have in-service training to learn basic information about AIDS and infection control procedures. Parents may be invited to the school for parent information nights where AIDS and HIV infection are the topic of conversation, or may be asked to assist with educational efforts at home that involve the discussion of family values as they apply to sensitive issues surrounding HIV infection. Various community professionals may be asked to serve as guest speakers or become otherwise involved with the school program.

Instruction: A comprehensive, sequential health education course of study—one that includes discussion of HIV infection in the context of units on sexuality, communicable diseases, and substance abuse—should be provided for all students in grades K through 12. The goals and objectives should be clearly stated. Lessons should incorporate learning activities designed to raise awareness and comprehension and should stimulate appropriate decision making, behavior change, and social action. Program evaluation as well as an evaluation of changes in student knowledge, attitudes, and behaviors should be conducted. Further, information about sexuality, STDs, and HIV should be integrated into all disciplines.

Media: Various media (television, radio, newspapers, public transportation posters, billboards, marquee, pamphlets, comic books, leaflets, wallet cards, etc.) can be used to provide effective HIV prevention messages to youth. Media opportunities exist both within the school and the community at large. Theatrical and musical presentations are also effective techniques to raise students' awareness of their susceptibility to HIV infection.

Social Support/Role Modeling: Health theorists have identified social interaction as one of the most powerful variables in explaining health behavior. Students not only learn directly from teachers, parents, and peers, they also learn indirectly by observing the behavior of these influential individuals. To effectively discourage sexual activity, professional and peer educators must strive to change the social norm among teens from one in which "everyone is doing it" (having sexual intercourse), to one in which "everyone who is 'cool' or 'with it' is abstaining until they are ready to commit to a permanent monogamous relationship" or "everyone who is 'cool' or 'with it' is using a latex condom with a spermicide during sex."

Furthermore, all educators can be proactive in modeling support and empathy for individuals infected with HIV. This can be done informally when the topic comes up in

conversation or more formally in the classroom setting.

Direct Intervention: Students should be provided intervention strategies which seek to eliminate or modify risk behaviors*. Students at high risk for drug abuse may also be at high risk for HIV infection since the abuse of drugs is related both directly and indirectly to increased incidence of HIV infection. Students who abuse drugs may have impaired judgement and be more likely to engage in sexual activity which they otherwise might not do. According to the Comprehensive Drug Abuse Rehabilitation and Treatment Act of 1986, students defined as being at high risk for drug abuse and therefore having the greatest need for direct intervention strategies are the ones who meet any of the following conditions:

- Drop out of school.
- Have become pregnant.
- Are economically disadvantaged.
- Have a parent or guardian who is a drug or alcohol abuser.
- Have sustained physical, sexual, or psychological abuse.
- Have committed a delinquent act.
- Have experienced mental health problems.
- Have attempted suicide.
- Have experienced a disabling condition*.

Environmental/Facility Modification: The school environment can reinforce HIV education concepts taught in the classroom and prevention goals identified by policy mandates by altering the physical and psychological environment. At a minimum, the school and community environment can be modified by using bulletin boards, display cases, the public address system, and the local media to raise awareness of the issues surrounding HIV.

The provision of a comprehensive primary health care clinic as discussed in Chapter Two would be a modification that could have significant benefits. As an alternative, community agencies could provide a comprehensive health care clinic for adolescents at a site near the school. Both school-based and school-linked clinics should be readily accessible from school grounds and closely integrated with school personnel and programs.

Facility modification can occur in the community as well as the school. Area stores may be encouraged to display condoms prominently. Store managers should instruct clerks to be nonjudgmental if adolescents want to ask about or purchase condoms*.

Choosing Strategies

Successful strategies for HIV prevention should be sensitive to community values, effective, comprehensive, attainable, and within budgetary limits. Many strategies may be undertaken with modest investments of time and resources. Instructional programs that use available staff can be developed with minimal investments of time and money. Prepared curricula and lesson plans are available that could be introduced at an in-service program. HIV education objectives should be made clear to all school personnel through in-service programs so that these personnel may be a part of the HIV infection prevention initiative and provide additional education and prevention messages to students.

A multidisciplinary team may be appointed to coordinate instructional strategies in formal and informal

settings within the school. If instructional policies are developed and approved by the board, the entire school may be mobilized to respond in some way to meet the objectives. For example, art teachers could assign students projects such as preparing posters and displays to post on bulletin boards, English teachers could assign articles on AIDS or HIV for the school newspaper, and social studies teachers could motivate students to work for AIDS-related causes in the community.

As a starting point, planners should list all possible strategies. Pros and cons of each should be analyzed carefully. Within the school and community settings, programmers should select tentative strategies for as many channels as possible. Figure 3.2 lists examples of strategies that may be employed by the various leaders in the school and community as well as by parents and students*.

This is but a partial listing of the interventions that could be provided. Examples of educational strategies and student learning activities are provided in the ensuing discussion. Student involvement is expanded even further in Chapters Four and Five.

HIV Education as Part of the Health Education Curriculum

As was stated in the beginning of this chapter, HIV education should be instituted as part of the health curriculum. The purpose of a comprehensive school health curriculum is to enhance the health of youth as well as to enhance their health-related skills, attitudes, and practices.

The following student activities are offered for possible inclusion in the HIV education component of the comprehensive health curriculum. *These activities may not be appropriate for every school district and therefore educators should use discretion when selecting activities. All activities should be consistent with school policies.*

- Develop a glossary of terms related to HIV infection (e.g., HIV, immunodeficiency, opportunistic infection).
- Monitor newspapers for AIDS or HIV-related articles. Discuss late-breaking HIV news each week.
- Identify behaviors that place one at risk for HIV infection.
- Prepare a skit portraying the immune system's normal response to infection with tuberculosis bacteria. Compare it with the immune system's response to HIV.
- Investigate the important role of the immune system. Suggest ways to strengthen it such as exercise, proper nutrition, and adequate rest.
- Compare and contrast various viruses, their target organs, and their modes of transmission.
- Practice decision-making skills and role-playing scenarios in which HIV transmission is possible. Include questions such as "What should Mark do?" or "How should Janet go about telling her parents?"
- Prepare articles for the school newspaper on STDs, HIV infection, clinics for counseling and testing, and risk behaviors to avoid. Encourage periodic editorials about AIDS and HIV infection.
- Develop and use a rating scale to evaluate the accuracy of information about HIV infection provided by the media (video and print media of all types—even supermarket tabloids). The scale could include criteria such as scientific

Figure 3.2

AIDS/HIV Infection Prevention Strategies

	Total School Environment Superintendent Principals Administrators	Classroom Instruction Elementary Teachers Secondary Teachers Content Specialists & Librarians	Health Services Nurses Nurse Practitioners Physicians
Policy	Development of Policies 1) Admission of Staff/ students with AIDS/HIV 2) Management of AIDS hysteria 3) AIDS instructional mandate 4) Confidentiality procedures for both students and staff 5) Identification & referral procedures for high-risk students 6) Primary health care clinic	Comply with all AIDS/HIV policies and assist with their development if requested	Implement body fluid management policy Comply with all AIDS/HIV-related policies and assist with their development if requested
Instruction	Institute an AIDS/HIV Awareness Week, incorporating instruction in all content areas Institute incidental AIDS/HIV instruction during other appropriate health promotion observances Reinforce & support the implementation of instructional policies	Develop & implement sequential K-12 AIDS/HIV instruction into the comprehensive health education curriculum Integrate AIDS/HIV instruction into curriculum of other academic content areas Develop instructional strategies which promote awareness, knowledge, decision-making, behavior change & social action Coordinate extra-curricular AIDS/HIV instruction within school program Create independent learning centers which focus on AIDS/HIV Develop instructional strategies which incorporate an examination of social, ethnic, religious & cultural mores regarding critical AIDS/HIV issues Provide information and support regarding psychosocial and psychosexual needs of students	Coordinate supplemental AIDS/HIV instruction Conduct in-service programs on the management of body fluids Serve as the liaison with public health workers in regard to HIV-positive/AIDS management Facilitate updating coworkers on AIDS developments & infection control procedures Cooperate with health teachers & counselors in the development of an information exchange network between school & community
Media	Provide AIDS/HIV prevention messages via school PA system	Use student newspaper to deliver AIDS/HIV prevention updates; sexuality education Use AIDS/HIV prevention videos	Develop and distribute infection control media for faculty/staff Distribute factsheets on HIV, Hepatitis B, Cytomegalovirus (CMV), etc. Provide easily accessed pamphlets about the location of anonymous testing sites
Role Modeling/ Social Support	Model support for individuals with AIDS/HIV	In conjunction with the counselor, develop peer instruction programs Develop instructional sequences involving parents & community professionals Model support for individuals with AIDS/HIV infection	Refer students at risk to appropriate support networks Model support for HIV-positive individuals Use proper infection control procedures
Direct Intervention	Support and enforce established intervention programs and policies Identify local STD clinics/anonymous testing sites in student handbook directory	Facilitate self-referral of high-risk students for intervention programming Create an atmosphere sensitive to the esteem and social needs of the individuals with AIDS/HIV in the classroom Facilitate home instruction for students with AIDS/HIV during periods of absenteeism	In conjunction with the counselor, develop specific programming for self-referred individuals engaging in high-risk behavior Facilitate private physician's prescribed medical regimens for students with AIDS/HIV Provide confidential and nonjudgmental referral for those seeking AIDS/HIV information or treatment Facilitate self-referral of high-risk students for intervention programming
Environmental Change	Enforce AIDS/HIV policies Establish primary health care clinic with reproductive service Use halls and display cases to raise AIDS/HIV awareness	Implement policies regarding body fluids. Use teachable moment to reinforce AIDS/HIV education messages Demonstrate acceptance of staff/students with AIDS/HIV Display posters & exhibits on AIDS/HIV prevention & sexuality education	Implement primary health care clinic with reproductive health care services Use clinic areas to raise AIDS/HIV awareness.

Adapted from: Allensworth DD, Symons C. A theoretical approach to school-based HIV prevention. *Journal of School Health* 1989; 59: 59-65.

Physical Education	Counseling	Worksite Health Promotion	Integrated School & Community
Content Specialists Coaches Trainers	Counselors Psychologists Social Workers	Director Faculty/Staff	Parents Peers Community Members
Comply with all AIDS/HIV policies	Comply with all AIDS/HIV policies and assist with their development if requested	Comply with all AIDS/HIV policies	School board policies developed with sanction and support of school/community task force Develop task force/coalition for AIDS/HIV policy development if not present
Use teachable moment to reinforce AIDS educational message: 1) relation of physical fitness to healthy immune system 2) the necessity for following policy guidelines for injuries involving blood	Cooperate with health teachers & nurses in the development of an informational exchange network between school & community Cooperate with health teachers & nurses in the development of parent training programs Provide supplemental AIDS instruction via guidance program Provide confidential counseling regarding psychosocial and psychosexual needs of students	Coordinate in-service programming which examines: 1) AIDS/HIV from a personal & school-based perspective 2) AIDS/HIV policies & implementation procedures 3) Management of AIDS hysteria	School board develops proactive stand justifying AIDS/HIV instructional programming Develop programming for PTA which outlines rationale for policy Develop parent training programs in regard to AIDS/HIV issues Use the school as an information broker for dissemination of AIDS/HIV information Use the following community resources for instructional support: public health dept., local physicians, nurses, or social workers, gay groups, and AIDS task forces Coordinate AIDS/HIV instructional programs among religious & youth serving organizations Organize youth performing arts groups to carry AIDS/HIV prevention messages Organize youth volunteers to serve in hospices
	Provide easily accessed pamphlets about the location of STD clinics/anonymous testing sites	Use faculty/staff newspapers and paycheck envelope stuffers to deliver AIDS/HIV prevention updates Provide easily accessed pamphlets about the location of STD clinics/anonymous testing sites	Develop PSAs for radio, T.V., and newspapers Develop local T.V./radio programs around teen sexuality & AIDS/HIV issues Use local media to highlight school's programming on AIDS/HIV Organize a parental task force to advocate for the depiction of responsible sexual activity in the media
Refer students at risk to appropriate support network Model first aid/infection control precautions for bleeding	Develop peer instruction programs targeting specific subpopulations Develop support groups for students in high risk situations Develop support groups for students or significant others with AIDS or HIV-positive test	Develop support networks for faculty and staff with AIDS/HIV	Coordinate support networks for staff/students with AIDS/HIV
Facilitate self-referral of high-risk students for intervention programming Adapt physical activity programs for the student with AIDS as needed	In conjunction with the school nurse, develop specific programming for self-referred individuals engaging in high risk behaviors Develop crisis management procedures for students faced with AIDS/HIV issues in self, teachers, or significant others such as: HIV-positive test, death and dying, homophobia, homosexuality Coordinate referral networks between the school and community		Develop community programs for in-school and drop-out populations. Coordinate school and community referral and support networks Provide confidential or anonymous, STD and HIV testing & counseling at local easily accessed clinics
Use the physical education and athletic facilities to raise AIDS/HIV awareness	Integrate counseling role into primary health care clinic Use the counseling facilities to raise AIDS/HIV awareness	Use the faculty/staff room to raise AIDS/HIV awareness	Use all community agencies to raise AIDS/HIV awareness via posters, displays, exhibitions Display & openly promote condom distribution in community clinics

accuracy, credible information source, and type of publication. This exercise could be used in tandem with a unit on consumer health.

- Debate pros and cons of mandatory HIV antibody testing for prospective newlyweds, prospective parents, job applicants, military recruits, health insurance applicants and customers, prostitutes, inmates, and injected drug users.
- Design an advertisement for responsible sexual behavior.
- Prepare bulletin boards throughout the school that depict HIV's economic and social impact on society, HIV's physical, social, and emotional impact on the individual, and the risk of contracting HIV.
- Write a report updating cognitive information about prevention, characteristics, symptomatology, diagnosis, and treatment of STDs (including HIV infection).
- Create bumper stickers, radio spots, and public service announcements that inform youth of their risk for HIV infection.
- Analyze the historical evolution of AIDS case incidence, prevalence, reporting, social policy, and management. (This activity also is appropriate for social studies classes.)
- Debate the issues of confidentiality and anonymity as they relate to individual privacy and the public's "right to know."
- Develop lists identifying ways HIV has and has not been transmitted.
- Debate the pros and cons of various contraceptive techniques to prevent 1) pregnancy and 2) the spread of HIV.
- Evaluate various types of condoms for protection against HIV infection. This may help erode barriers to talking about condoms. (The activity could also be done in science class.)
- Participate in peer education networks to advance knowledge regarding HIV, risk behaviors, and available health services.
- Design a survey to measure knowledge, attitudes, and behaviors about HIV and AIDS. Interview students at various grade levels, parents, and community members. Compile results, make recommendations, and submit to the school newspaper.
- Solicit "Dear Abby" letters about HIV infection from class members. Have a student panel prepare appropriate responses.
- Identify high-risk behaviors, discuss why adolescents engage in them, and suggest strategies that might convince youths to avoid them.
- Identify students' roles as advocates for HIV prevention.
- Replicate the Center for Population Options study which assessed community attitudes towards adolescents purchasing condoms⁹.
- Conduct a survey of the student body to determine their impressions of why some of their peers who are sexually active do not use contraceptives.
- Develop role plays of strategies that sexually active adolescents may use to encourage condom use.
- Create soap operas about adolescent sexual decision making and coping with peer pressure. Incorporate decision-making, coping, refusal, and other risk-reducing skills.
- Conduct a schoolwide campaign to alert all students both

to their susceptibility to HIV infection and to how it may be prevented.

HIV Education Across the Curriculum

The Educators' Role

Although planned, sequential instruction focusing on HIV is basic to the health education curriculum, HIV instruction can and should be integrated into other subject areas in order to increase the possibility that health-enhancing behaviors will be adopted. Besides health teachers, those in art, English, home economics, mathematics, music, science, and social studies have opportunities to reach students with information about HIV infection and its prevention. Educators can make a difference since 1) they can determine the focus of the learning activities within their classes and 2) they can be models for appropriate health-enhancing attitudes and behaviors. Most educators could employ specific activities such as the following:

- Inviting a representative from a local AIDS task force or health department to speak to students about HIV infection.
- Inviting a PWA to speak to the class.
- Developing self-instruction packets on HIV infection. Construct packets to measure knowledge gain, attitude formation and the adoption of healthy lifestyles through behavior contracting. (Appendix D contains a sample self-instruction packet.)
- Referring to the nurse, counselor, or anonymous testing site those students who feel they may be at risk of HIV infection.
- Modeling empathy for PWAs and discouraging discrimination.
- Inviting students who might be at high risk for HIV infection to participate in special programming.
 - Soliciting parental involvement in the HIV instructional program. Include (in self-instruction packets) homework that involves parents and supports contracting to modify behavior.
- Providing supplemental learning experiences using microcomputers and software. Samples of such software include the following:

AIDS Education (1990). An interactive computer program providing factual, medically based information. Covers how AIDS affects the body, transmission, risk factors, and prevention. Includes a self-administered review quiz. Apple or IBM software price is \$49.95. Available from: HEALTH EDCO A Division of Spence Research Inc., P.O. Box 21207, Waco, TX 76702-1207, 1(800) 433-2677.

STD: A Guide for Today's Young Adults (1987). A computer-assisted tutorial written especially for adolescents in grades 6 through 12. Color graphics and interactive question sequences are used to explore various STDs; a special in-depth section on AIDS is included. Program disks, instructor's manual, and student guide are included. The price for Apple 6-disk set is \$20; for 2 disk IBM version, \$15. Available from: Georgia State University Foundation, Department of Medical Technology, University Plaza, Atlanta, GA 30303, (404) 651-3034.

Understanding AIDS (1989). One in a series of computer-assisted education programs from Substance Abuse Education Software. Program features include color graphics, reference glossary, self-tests, and a special interest file. Designed for grades 7 through 12. Content is based on the Surgeon General's recommendations and follows CDC guidelines for School Health Education to Prevent the Spread of HIV infection. Price is \$49.96 for Apple II, IBM-PC, or Tandy computers. Available from: Substance Abuse Education, Inc., 670 South 4th Street, Edwardsville, KS 66113, (913) 441-1868.

Student Classroom Activities Across the Curriculum

The following student classroom activities are organized under specific subjects. In practice, many exercises could be appropriate in several subjects. No attempt was made to group these activities developmentally. Therefore, educators should use discretion when selecting these activities for use in their classroom and use them only if consistent with school policy. Because activities for health were discussed at the opening of the chapter, they are not included in this section.

Art

- Depict the human immunodeficiency virus in a drawing or painting.
- Produce and display signs identifying clinics that provide reproductive health services to adolescents.
- Produce abstract artwork expressing the emotional impact of HIV infection on an individual.
- Produce and display posters depicting the threat of HIV infection to adolescents, the need for abstinence until older, and if sexually active, the use of risk-reduction behaviors.
- Construct a collage depicting the threat of HIV infection to adolescents or the impact of HIV on the individual.
- Construct a mobile of HIV and causative organisms of other STDs.

English-Language Arts

- Prepare a glossary of HIV terminology.
- Prepare written and oral book reports using fiction and non-fiction books about HIV infection and AIDS. Use books listed in Appendix C ("Library Resources") or other appropriate sources.
- Write scripts for the individual infected with HIV who must tell a loved one or sexual contact about the infection.
- Construct a file of newspaper clippings on HIV to be used in a monthly update.
- Write letters to consenting PWAs in local hospitals or hospices.
- Write letters to health officials asking for specific information on HIV and AIDS.
- Create a play about the impact of HIV infection on an individual, family, friends, and community. Perform throughout the school and community.
- Prepare a pamphlet that defines contraceptive techniques, pros and cons of various contraceptive methods, and a listing of community resources and support services for adolescents seeking reproductive health care.

- Write a poem that a person with HIV infection or AIDS might compose.
- Write an essay called, "How My Life Would Change if I Were Infected with HIV."
- Develop a persuasive argument or hold a debate concerning which strategy adolescents should use to prevent the spread of HIV: abstinence or risk-reduction behaviors.

Home Economics

- Research STD transmission and treatment.
- Investigate the special needs of infants born with HIV infection.
- Role-play situations in which parents talk to a child (ages 5, 10, and 15) about HIV.
- View several television programs and discuss the values they present regarding sexual activity. Encourage students to write the station management if they disagree with these values.
- Write an essay called "How to Care for a Person with AIDS."
- Research HIV's impact on the family.
- Identify the roles and responsibilities of school, home, and religious institutions in educating students and family members about HIV.
- Investigate the health impact of various STDs, including HIV infection on the developing fetus.
- Role-play a teen informing family members that he or she is infected with HIV.
- Identify a variety of family and social values relating to sexual activity. Determine the extent to which these values support HIV prevention.
- Develop a menu plan for the individual with HIV/AIDS.
- View a film or video on AIDS and HIV. Participate in a round-robin discussion on the impact of AIDS and HIV infection on the well-being of the family.
- Prepare a bulletin board ("What to tell a friend about HIV and AIDS") that describes how teens can help disseminate accurate information about HIV.
- Conduct a community youth forum on AIDS and HIV by using student panel members.
- Write a short story about how a family coped with the AIDS-related death of one of its members.

Mathematics

- Graph current AIDS morbidity and mortality rates in the United States. (Morbidity refers to diagnosed cases of AIDS; mortality denotes those who have died of the disease.)
- Calculate and compare the costs of a prevention program to the costs for treatment of a PWA.
- Map the reported numbers of new AIDS cases worldwide by three-year periods since 1980.
- Compute the potential population at risk if each person infected with HIV unknowingly infects two, four, or six others.
- Calculate and contrast the cost per person for treatment of a PWA to the cost of HIV education and services for your school.
- Graph the incidence and prevalence rates of AIDS and other STDs since 1981. Compare local and state public health records with national data.

Music

- Write a song for an advertising campaign highlighting the very real risk of teens contracting HIV.
- Compose lyrics for a song about HIV infection prevention or caring for a PWA.
- Identify popular songs with themes promoting sexual responsibility and preventing drug abuse.
- Create an original rap song (lyrics and instrumental) about HIV-related issues. Perform it at a school assembly and/or in the community.

Science

- Investigate the unique nature of retroviruses.
- Compare and contrast the immune system's response to bacterial and viral infections. Investigate treatment options for these infections.
- Research the prevention and treatment of HIV-related infections and AIDS; identify antiviral drugs.
- Examine how STDs (including HIV infection) can affect fetal development, birth procedures, and fetal care.
- Investigate and explain how HIV affects the immune system.
- Demonstrate the barrier effects of condoms by using food coloring and water. Conduct experiments to determine the strength of various brands.
- Schedule a visit to a blood bank or the American Red Cross to observe procedures for protecting the blood supply. If students are old enough, they may also wish to donate blood in order to observe the procedures first-hand and report to the class on the experience. *(Blood donation should be considered an optional activity. No student should feel pressured to donate blood.)*

Social Studies

- Identify the impact of STDs on the lives of historical figures.
- Identify how HIV infection affects the individual, the family, and the community.
- Interview a private physician and a public health clinician about diagnosing, reporting, counseling and testing for, and controlling STDs in general and HIV and AIDS in particular.
- Develop a list of community agencies that provide reproductive health services to adolescents. Note fees and hours of operation.
- Investigate laws and policies regarding prevention of HIV transmission in schools, the workplace, and health care settings.
- Examine school policy and community attitudes toward school attendance of students, faculty, and/or staff with HIV/AIDS.
- Investigate the economic, social, legal, and medical effect HIV and AIDS have on the United States and other nations.
- Analyze the impact of the HIV epidemic on issues such as homosexuality, homophobia, gay rights, general public response to mandatory testing, quarantines, school attendance of persons with communicable diseases, and the issuing of free IV needles and syringes to drug addicts.
- Simulate a community with a child who has AIDS. Role-play various community members at a town gathering or school board meeting.

- Conduct a debate regarding various social issues surrounding HIV infection.
- Assemble a panel of local religious leaders to discuss HIV-related issues from their religious/moral/ethical perspectives.

As noted above, with the help of their teachers, students can learn about HIV and AIDS in many subject matter areas. Other school personnel can also play a role.

The Librarians' Role

The librarian can support the educational mission to prevent HIV infection in students by doing the following:

- Constructing thematic bulletin boards promoting HIV infection prevention.
- Displaying fiction and nonfiction books on sexuality and STDs.
- Organizing a film festival promoting prevention of HIV infection and other STDs.
- Maintaining a wide selection of current HIV education materials, including the resources listed in Appendix C.

School Nurses' and School Physicians' Roles

School nurses and physicians have a special responsibility to keep abreast of the latest HIV developments, to serve as the HIV resource persons for school personnel and students, and to work with AIDS and HIV units of local and state health departments. These personnel can advance the intervention program in a variety of ways:

- Using the nurse's room or primary health care clinic to raise HIV awareness via posters, pamphlets, and displays.
- Providing supplemental instructional programs on adolescent sexual health, including the prevention of STDs and HIV infection.
- Initiating a discussion of HIV prevention with all students at the clinic, regardless of what they are being treated for.
- Providing a directory of school and community services that jointly serve STD, family planning, and maternal and child health needs; identify HIV antibody testing sites.
- Providing confidential referrals and counseling for STD and HIV antibody testing.
- Facilitating confidential STD and HIV referral networking for students who seek information or treatment.
- Establishing a peer support network to advance knowledge of STDs and appropriate prevention measures.
- Disseminating basic information on STDs and HIV via pamphlets, mini-lectures, and audiovisual programs.
- Assisting in developing school-based HIV policies.
- Providing in-service training, education, and updates regarding HIV and AIDS for school personnel and health professionals. Provide demonstrations on safe management of blood and body fluids. Develop and distribute infection control material for faculty, staff, and students.
- Initiating a column in the student newspaper called "Ask a School Nurse," which provides questions and answers about HIV.
- Conducting a survey to assess student knowledge and behaviors regarding HIV infection. Provide follow-up information and instruction.
- Developing periodic fact sheets on HIV for students, faculty, and staff.

- Serving as a role model for HIV infection control and treatment of PWAs or persons infected with HIV.
- Monitoring and ensuring the continual availability of infection control supplies.
- Contacting local, state, and national organizations with HIV/AIDS expertise to secure scientific information and instructional materials.
- Assuming responsibility for the worksite wellness program if no director is available.
- Familiarizing yourself with HIV position and policy statements developed by national associations such as the American School Health Association (See Appendix E) and the American Nurses' Association below:

American Nurses' Association Statement

In a 1987 policy statement, the American Nurses' Association 1) opposed universal mandatory testing for HIV, but supported voluntary anonymous testing for persons who have given informed consent and received appropriate counseling from qualified health care professionals, 2) urged substantial federal support for HIV education, research and treatment, 3) reaffirmed its commitment to protecting the civil and human rights of affected people and their caregivers, 4) acknowledged and reaffirmed the profession's commitment to care for all who suffer from AIDS, and 5) urged all health care workers to follow CDC guidelines for preventing the spread of HIV in the workplace.¹⁰

Physical Educators' Role

Of all the teachers in the school, the physical educator, who many times is also a coach, is most likely to have an opportunity for a more informal level of student involvement. Perhaps this is due to the nature of this teaching position. Physical educators who are also coaches spend a great amount of additional time with students in a coaching situation where the opportunity for informal as well as formal interaction presents itself. This opportunity particularly lends itself to the "teachable moment." In addition, physical education teachers and coaches are expected to be knowledgeable about the potential for transmission during "contact sports," or as a result of an athletic injury in which the skin is broken. The majority of physical educators also teach health courses. Even if they do not teach health, by the nature of their position they are concerned about this topic. The physical educator or coach can assist with HIV infection prevention programs by doing the following:

- Complying with all school HIV infection and AIDS policies.
- Using the "teachable moment" to reinforce HIV education messages (e.g., at the time of an accident or injury involving blood teach the importance of following infection control procedures).
- Placing information about HIV infection and AIDS in the athletic event program or other athletic or physical education department publications.
- Referring students at risk to appropriate support networks.
- Modeling proper first aid/infection control procedures for bleeding.

- Facilitating self-referral of high-risk students for intervention programming.
- Adapting physical activity programs, as needed, for the student with AIDS.
- Using the physical education and athletic facilities to raise awareness of HIV infection and AIDS.

Counselors', Psychologists', and Social Workers' Roles

Counselors, psychologists, and social workers have a responsibility to serve as the specialists who provide instruction, counseling, and social support to the school community. These individuals can assist with HIV infection prevention programs by doing the following:

- Establishing a walk-in crisis center and appropriate referral network providing immediate and long-term confidential counseling.
- Using counseling facilities to raise HIV awareness. Display and distribute pamphlets that describe STD and HIV prevention practices and that provide locations of local anonymous testing sites.
- Developing specific intervention programming for individuals who have identified themselves as engaging in high-risk behaviors.
- Developing a peer counseling program addressing issues facing today's youth, such as risk behaviors, STDs (including HIV infection), HIV antibody testing and counseling, contraception, drug abuse, and concerns about loved ones who may be infected with HIV.
- Arranging for peer counselors to be in "drop-in rooms" where students can meet during free periods in the school day.
- Providing information within the guidance program about STD and HIV infection prevention.
- Implementing programs promoting self-esteem and decision-making, communication, and coping skills. An example of such a program is *The Dynamics of Relationships* (contact Patricia Kramer, Equal Partners, 3371 Beaverwood La., Silver Spring, MD 20906, (301) 871-9667 or (301) 871-9665).
- Providing programs in which parents and students work together to enhance communication, refusal, and decision-making skills regarding sexuality.
- Offering before- and after-school mini-programs addressing esteem-building, assertiveness skills, and decision-making, refusal, conflict resolution, and communication skills.

The Director of Worksite Wellness Programs' Role

The director of worksite wellness programs can also be enlisted to support the HIV education mission. Although the main focus of the faculty/staff wellness program will be to prevent HIV infection in school personnel, the programming provided by the faculty/staff wellness program can be used by teachers to convey information to their students during class time and through informal conversations. Specific strategies might include:

- Providing in-service programming to reduce personal risk of HIV infection and to develop a level of personal comfort in dealing with HIV issues.

- Posting for faculty and staff the locations of anonymous HIV counseling and testing sites and the numbers for the U.S. Public Health Service AIDS Hotline, 1-800-342-AIDS, 1-800-344-SIDA (Spanish Language), 1-800-AIDS-TTY (Hearing Impaired).
- Providing HIV messages via staff newsletters and personal communications.
- Posting newspaper clippings on HIV in faculty/staff lounge areas and fitness facilities.
- Developing support networks for faculty and staff who are infected with HIV.
- Inviting community health professionals to provide HIV updates to faculty and staff.
- Attending community adult and continuing education programs on HIV.

Administrative Support

The School Board's Role

School boards can contribute to effective HIV education programs through a variety of supportive measures. Especially critical is the need for the board to develop policies that address the main issues surrounding HIV prevention. The board may also take the lead in the establishment of a school-community response to prevent the spread of HIV infection. Specifically, boards may become active in the prevention of HIV by initiating the following strategies:

- Enlisting the assistance of the public health department and other knowledgeable health professionals to serve as consultants to be used as content specialists for all HIV-related issues.
- Adopting policies and guidelines that address the following:
 - education/employment of students/employees with HIV infection.
 - confidentiality of records of HIV-infected students/employees.
 - management of unwarranted concerns and reactions based on fear of AIDS and HIV infection.
 - infection control procedures.
 - HIV education programs.
- Consulting the National School Boards Association (NSBA) and the National Association of State Boards of Education (NASBE) for HIV policy information.
 - NSBA has a policy information clearinghouse that includes HIV-related and health education policies, regulations, and background materials. (See Appendix F for samples.) Contact: NSBA, 1680 Duke Street, Alexandria, VA 22314, (703) 838-NSBA.
 - NASBE has published *Someone at School Has AIDS*, a guide to developing policies for students and school staff members who are infected with HIV, and *Effective AIDS Education*, a policymaker's guide. Contact: National Association of State Boards of Education, 1012 Cameron Street, Alexandria, VA 22314, (703) 684-4000.

Both NSBA and NASBE have published results of survey research they have conducted. Contact the individual organizations for printed copies of results of their survey research.
- Requesting the NSBA Leadership Reports, *AIDS and the*

Public Schools and Reducing the Risk: A School Leader's Guide to AIDS Education, from the NSBA address above.

- Familiarizing yourself with the NSBA resolutions on HIV/AIDS, which follow. The NSBA adopted these resolutions in 1989 and had similar resolutions in 1987 and 1988:

NSBA Resolutions Enacted by the 1989

Delegate Assembly

Communicable Diseases and HIV: NSBA believes that all local school boards should adopt policies for handling communicable and reportable diseases, including HIV (human immunodeficiency virus) infection and disease. School boards must develop an educational program for school staff, students, and community to provide factual information about HIV and its infectious risks as a means of combatting people's fears and misconceptions about HIV. In drafting policies on communicable and reportable diseases, school boards must balance the need to protect the health of students and employees with the need to protect each individual's civil rights and privacy.

Curriculum on HIV Prevention: NSBA believes that all local school boards should adopt curriculum to educate students as to the causes of HIV infection and disease and the means to prevent acquiring the infection¹¹.

- Adopting and providing adequate funding for a sequential, K through 12, comprehensive school health education curriculum that includes HIV instruction.
- Providing for periodic HIV and health education in-service programs for faculty, staff, and administrators.
- Providing for community HIV education programs, preferably before the first individual infected with HIV enters school.
- Establishing a school health interagency network linking the schools with health and educational services of community agencies serving children and youth.
- Initiating the development of a school community effort on HIV infection prevention if none exists in the community.
- Initiating the establishment of a school-based or school-linked comprehensive primary health care clinic in conjunction with public and private health care systems in the community.
- Initiating the development of a health promotion/wellness program for faculty and staff that includes an Employee Assistance Plan (EAP) that would address the prevention of HIV infection as part of broader wellness issues.

School Administrators' Role

Administrators can support HIV prevention by:

- Developing detailed protocols based upon policy for integrating a person with HIV infection (student or staff) into the school program; managing unwarranted concerns and reactions based on fear of AIDS and HIV infection; protecting the confidentiality of individuals infected with HIV; and providing HIV instruction as part of a comprehensive, K through 12 health education program.
- Participating in "World AIDS Day" by directing all content and pupil service areas to integrate and coordinate central themes of being sexually abstinent, avoiding

drug-related behavior, and preventing HIV infection and other STDs.

- Providing HIV prevention messages periodically during morning announcements over the school public address system or on bulletin boards.
- Establishing a comprehensive primary health care clinic, including reproductive health care, on the school site. The clinic should be staffed by a school nurse or nurse practitioners. The nurse may have part-time collaborators, such as physicians, nurses, psychologists, counselors, and paraprofessionals. If a school-based clinic is not feasible, the ASHA recommends that the school nurse work with a nearby comprehensive primary health care clinic. Under this arrangement, the school nurse may practice both independently and collaboratively with the clinic; the school nurse may be considered part of the clinic staff, and the clinic staff may be part of the total school health services program. Clinic and school health services personnel roles should be derived collaboratively and delineated clearly.
- Conducting a schoolwide contest with prizes for the best song, essay, poster, and jingle promoting prevention of STD and HIV infection. Hold an assembly to present winning entries and award prizes.
- Arranging for scientifically accurate and educationally sound in-service updates on HIV for personnel, parents, and school board members. Programs should address the roles of school-based professionals and parents in preventing the spread of HIV infection.
- Establishing an HIV school health advisory council or a school-community interagency network. Council subcommittees, as identified by the American Association of School Administrators, may cover needs assessment, community awareness, HIV instructional philosophy, and community resources identification¹².
- Reviewing existing HIV education resources to incorporate into the health education program. This exercise may be conducted by the assistant superintendent for curriculum and instruction. The school health advisory council or curriculum committee may also be assigned this task.
- Being prepared to address local questions and controversies. Preparation should be completed before any specific incidents arise.
- Accepting a major role in creating a healthful, supportive, and positive school environment. Assess and improve physical, social, and emotional aspects of the school climate/environment.
- Encouraging parents to be partners in their children's learning process. Welcome them into schools and encourage classroom visitations. Encourage teachers to assign homework that involves parent-student interaction.
- Conducting community awareness programs stimulating rational discussion about, and acceptance of, HIV programming. See *Dealing with AIDS: Breaking the Chain of Infection, A Guide for Developing an AIDS Education Program*. American Association of School Administrators, 1801 North Moore Street, Arlington, VA 22209-9988.
- Making infection control supplies, such as latex or vinyl gloves and bleach, available to faculty and staff. Provide all staff with in-service training on infection control.

Integrated School and Community

No single institution within a community, including schools, can be responsible for all HIV education. Comprehensive programs integrate the efforts of religious institutions, community agencies, parents, schools, youth-serving agencies, and health organizations¹³. To enhance programming aimed at reducing or eliminating HIV infection, partnerships among several community agencies should be formed. Partners in this endeavor might include public health departments; physicians in private practice; local constituent organizations of national professional associations for physicians, nurses, or social workers; local AIDS task forces; universities or colleges with schools of medicine, nursing, public health and/or departments of health education; voluntary health agencies such as the American Red Cross; clinics, hospitals, and hospices; and social and youth-serving agencies.

Parents' Role

All parents provide sexuality education to their children. They do this informally through a variety of means such as treating children differently because of their gender, choosing terminology for sexual organs and sexual anatomy, being selective in the way they hold and touch their offspring¹⁴, and displaying love and affection to the children as well as to each other. The formal communication of sexual information sometimes is more difficult for many parents. Almost 80% of parents feel a need for help in providing this instruction¹⁴. It is critical that parents receive this assistance because a number of research studies have documented the value of parental involvement in the acquisition of health-enhancing behaviors^{15,16,17}.

Parents need to be involved in the HIV prevention effort. They should be notified (through school newsletters or parent information nights) about HIV prevention activities the school is conducting. The PTA is the logical linkage between the school and the home. PTA newsletters may be used to inform parents about upcoming HIV-related events. School officials can request that local newspapers, television stations, and radio stations broadcast information about these events as a public service.

Students can be great motivators of their parents. Students can inform their parents about HIV prevention activities in the school and solicit their involvement. They may also get parents involved in community activities related to preventing HIV infection and AIDS. Some curricula involve parents in the HIV education program. If the school does not use such a curriculum, teachers may give students HIV-related assignments to take home and complete with their parents. The Centers for Disease Control has developed a guide for parents to use in educating their children at home about AIDS and HIV infection. This "AIDS Prevention Guide" has been advertised on national television and is available free from the National AIDS Information Clearinghouse, P.O. Box 6003, Rockville, MD 20850, (800) 458-5231.

Additional strategies for parents include the following:

- Encouraging the school board to adopt a multidisciplinary approach to HIV prevention.
- Ensuring that children receive high-quality, developmentally appropriate HIV education as part of a comprehensive school health education program.

- Discussing the advantages of abstinence or of postponing sexual activity until older. If a child is sexually active, promote responsible sexual behavior, including risk-reduction practices.
- Requesting and participating in a PTA meeting on preventing STDs (including HIV infection) among adolescents.
- Requesting and attending community education classes on child development, human sexuality, and learning how to talk to children about sexual matters.
- Expanding sexuality knowledge by reading books such as *Straight Talk: Sexuality Education for Parents and Kids* (New York: Viking Penguin Inc., 1985) or Carole S. Marsh's *Sex Stuff: A Book of Practical Information and Ideas for Kids 7-17, and Their Teachers and Parents* (Bath, NC: Gallopade Publishing Group, 1987).
- Using resources identified in Appendix C under *Books for Adults Working with Youth* to enhance communication skills and knowledge about HIV infection. Use these books to facilitate family discussions on HIV issues.
- Becoming an "askable parent" who can be approached for information and guidance.
- Initiating periodic HIV/AIDS awareness talks with children. Explore their fears and concerns and correct any misinformation.
- Requesting that school and community libraries expand their fiction and nonfiction collections of books, for children and adults, that address sexuality in general and HIV/AIDS in particular. (See Appendix C for suggested readings.)
- Writing to television networks and local stations to request that their programming portray responsible sexual behavior.
- Discouraging the abuse of alcohol and other drugs, which may lead to high-risk behaviors.
- Serving as a role model of responsible behavior.

The Community's Role

Many organizations and agencies within a community may have a specific HIV prevention program. If these organizations can be brought together to work collaboratively, they will provide more information and additional services to youth, attract more financial resources, collect more accurate data on youth being served, and create the foundation for services required by adolescents¹⁴. Strategies for community groups include the following:

- Coordinating systematic instruction, for parents and children in religious institutions, on human sexuality, STD (including HIV) prevention, teen pregnancy, and drug abuse. A valuable resource is *Sex Education in a Church Setting: The OCTOPUS Training Manual*. Carbondale, IL: Southern Illinois Press, 1987. OCTOPUS is an acronym for Open Communication regarding Teens' Or Parents' Understanding of Sexuality.
- Coordinating systematic instruction on sexuality and HIV, drug abuse, and pregnancy prevention as part of the programming of youth-serving agencies.
- Conducting a communitywide HIV awareness campaign, including messages about prevention, and positive, compassionate treatment of HIV-infected individuals.
- Using community marquee to display messages;

producing newspaper ads and radio and television public service announcements.

- Organizing community service projects for school-age youth in community agencies to convey HIV prevention methods to dropouts and runaways; in hospitals and hospices, providing PWAs with assistance and companionship; and in social service agencies such as welfare offices, unemployment agencies, and clinic waiting rooms, providing HIV infection prevention messages to clients.

Implementing Plans

After strategies such as the ones suggested above have been identified, the next step in program planning (as outlined in Figure 3.1) involves implementing the plan. To implement the chosen strategies, a detailed action plan that outlines the activities necessary to accomplish the strategy must be developed. At a minimum, the plan must address the following details: 1) a step-by-step analysis of each activity necessary to accomplish the strategy, 2) a listing of the personnel responsible for completing the activity, 3) a timetable, 4) an analysis of the resources necessary for each activity; needed resources may include money, personnel, facilities, skills, and media, and 5) the development of an evaluation plan, which will be discussed at the close of this chapter. Table 3.3 provides an example of a planning sheet that might be used to outline the personnel, time line, and resources needed for each strategy. Further, the planning sheet delineates the relationship among the goal(s), objective(s), and strategies.

Table 3.3

HIV Prevention Implementation Planning Sheet

Goal(s):	Objective(s):	Strategies:	Individual Responsible	Completion Date	Resources Needed: Money/Skills/Facilities/Materials

Use of a planning sheet for each objective ensures that the strategies chosen to attain that objective have been translated into an action plan. In reality, the chosen strategies might meet more than one objective, or more than one strategy may be initiated for each objective. For example, to attain a knowledge objective, the planner might use formal classes, media displays, and peer instruction. Table 3.4 provides an additional example of using multiple strategies to meet one objective. In this example, multiple strategies are listed to attain the following objective: 50% of

the faculty will discuss an HIV prevention message with students a minimum of once a month. The same strategies could be used if an objective of the HIV prevention plan were as follows: By the end of the year, all staff will be able to describe accurately the routes of transmission of HIV. The action plan not only addresses each objective but provides sufficient strategies to ensure that the objectives will be attained.

To build enthusiasm and participation in the HIV/AIDS education action plan, attention must be given to publicity and marketing. These elements should be a part of the action plan. From the beginning, an interdisciplinary team at the school should be linked with community agencies. This expands the channels for communication as each individual uses his or her professional position and agency to market and publicize the program.

Although many strategies can be initiated without the need for extra funds, additional monies can serve to broaden the scope of the original action plan. Funding for health promotion programs to prevent HIV infection should be provided by school and community agencies. Interagency collaboration usually facilitates fund-raising efforts as well as grant procurement. Fund-raising efforts by students to support HIV/AIDS prevention programming can also be used to increase their awareness of the issues surrounding AIDS. For example, sponsorship for a walk or run could raise money to assist a local hospice or pediatric AIDS initiative. Students involved in such an activity are likely to have increased compassion for PWAs. The following resources may be helpful to those involved in fund raising efforts:

Fund-Raising Resources

Brody R, Goodman, M. Fund-raising events: strategies and programs for success. New York: Human Sciences Press, Inc., 1988. Office of Disease Prevention and Health Promotion. Locating funds for health promotion projects (3rd ed.). Washington, DC: US Government Printing Office, 1988. While supplies last, a single copy of this publication is available free from: ODPHP National Health Information Center, P.O. Box 1133, Washington, DC 20013-1133.

If a broad-based planning committee developed the HIV infection prevention program, the work load can be shared among the staff of several organizations. In addition, many member organizations will have access to volunteers and consultants who can ease the work load. When the efforts of professionals and volunteers are combined, careful planning and organizing is needed to keep both aware of their specific responsibilities and of how their roles support the entire program.

Evaluating Results

Evaluation is the final component of the planning process. The evaluation provides an assessment of the program design, execution, effectiveness, and efficiency. By identifying accomplishments and limitations of the program, the planners are assisted in making decisions about which elements of the program should be repeated, revised, or removed.

Table 3.4

HIV Prevention Implementation Planning Sheet

Goal: To reduce the incidence of HIV infection in students.
Objective: 50% of the faculty will discuss an HIV prevention message with students a minimum of once a month.
Strategies: 1) Develop periodic fact sheets on HIV for students, faculty, and staff
 2) Supplemental lessons on HIV
 3) Clipping service for HIV articles in newspapers and journals

Activity	Individual Responsible	Completion Date	Resources Needed: Money/Skills/Facilities
Periodic Fact Sheets on HIV			
Select team to write fact sheets	Principal	Week 1	
Call first meeting	Principal	Week 1	Meeting room
Team elects chair	Team	Week 3	
Gather resource materials	Team	Week 5	
Write first draft	Team	Week 6	Resource materials
Have outside experts review draft	Chair	Week 8	Expert panel, Central Office
Make any revisions that are necessary	Team	Week 10	
Print first bulletin	Secretary	Week 12	Desktop publishing or typewriter
Distribute first bulletin	Team	Week 12	School routing system
Repeat last five steps every 3 months	As above	Weeks 24, 36, 48	
Supplemental lessons on HIV			
Copy material for various disciplines	Curriculum Coordinator	Week 1	Copy ideas from this book
Arrange 45 minute in-service presentation	Principal	Week 1	
Prepare in-service presentation	Curriculum Coordinator	Week 4	Resource material
Deliver in-service presentation	Curriculum Coordinator	Week 4	Meeting room
Clipping Service			
Assign librarian task	Principal	Week 1	
Review local newspapers	Librarian	Weekly	Local newspapers
Review health, professional, and medical journals	Librarian	Weekly	Journals
Copy relevant articles	Librarian	Weekly	Copy machine
Distribute articles to appropriate faculty	Librarian	Weekly	School routing system
Display one copy in faculty lounge	Librarian	Weekly	Bulletin board

There are various types of evaluation. Formative and summative evaluation are commonly discussed in the literature. A formative evaluation produces information that is used to improve a program during its developmental stages. For example, a pilot study is commonly done for this type of evaluation¹⁸. Additionally, an evaluation of the program design can answer questions about the comprehensiveness, attainability, and validity of the program's goals, objectives, strategies, and activities.

Summative evaluations provide summary statements of a program's effectiveness over a specified period of time¹⁸. More immediate changes sometimes are referred to as impact evaluation, whereas long-term changes often are referred to as outcome evaluation. An evaluation of the program impact and outcome may assess changes in the knowledge, attitudes, and behaviors of students; increases or decreases in teen pregnancies and drug offenses; the number of referrals to anonymous counseling and testing sites, as well as the level of activity and the extent to which the program adhered to the plan.

Elements of the evaluation process include

- 1) formulating the questions to be asked, 2) identifying the techniques and personnel that will answer the questions, 3) soliciting the information, 4) analyzing the data, 5) reporting the results, and 6) using the evaluation results to plan successive initiatives¹⁹. An example of an evaluation plan is presented in Table 3.5.

ASHA, through a grant sponsored by the American Foundation for AIDS Research, has developed instruments to evaluate the comprehensiveness of school HIV/AIDS

education programs. These instruments assess four components of the school health program by asking questions of key individuals normally responsible for these component areas. A multidisciplinary team may find such instruments useful in assessing the current status of their program. The components that are addressed are located in Appendix G and include the following:

- School environment—school principal.
- School health services—school nurse.
- Counseling—school counselor.
- School health instruction—health educator.

Program planners may also find the following resources helpful for learning more about evaluating their programs.

Evaluation Resources

Books

Green LW, Lewis FM. Measurement and evaluation in health education and health promotion. Palo Alto, CA: Mayfield Publishing Co., 1986.

Commission on Behavioral and Social Sciences in Education. Evaluating AIDS prevention programs. Washington, DC: National Academy Press, 1989.

Commission on Behavioral and Social Sciences in Education. Evaluating AIDS prevention programs (2nd ed). Washington, DC: National Academy Press, 1991.

Rossi H, Freeman HE. Evaluation: a systematic approach. Beverly Hills, CA: Sage Publishing Co., 1982.

Windsor RA, Baranowski T, Clark N, Cutter G. Evaluation of health promotion and education programs. Palo Alto, CA: Mayfield Publishing Company, 1984.

Table 3.5

Evaluation Plan

Sample questions to be asked	Who will supply data?	What data will be used?	When will data be collected?
Has there been a decrease in STDs/teen pregnancy/drug abuse?	Health services, Clinic data Random sample of students	Number of positive diagnoses Number of referrals Number under treatment Self report survey	End of school year
Has knowledge about HIV prevention increased?	Health ed. students Peer ed. program participants Random sample of students	Pre/Post Test Pre/Post Test Survey	Beginning and end of class Beginning and end of training program End of school year
Has participation in specific health behaviors increased? (e.g., abstinence, safer sex practices)	Random, anonymous survey of students	Survey	End of school year
Have health care services personnel initiated discussions of HIV prevention with students?	Clinic personnel	Chart notations	Monthly
Which is more likely to be read: HIV prevention articles in school newspaper or messages on bulletin boards?	Random sample of students	Survey of readership	Six months from initiation of media campaign
How many peer instruction classes were provided?	Course Instructor	Compilation of class records	End of school year
How many students did each peer instructor reach?	Peer leaders	Activity log	Each month
From what social groups were the peer instructors drawn?	Peer leaders	Sociogram	End of each training session

Source: Allensworth DD, Wolford CA. Achieving the 1990 health objectives for the nation. Kent, OH: American School Health Association, 1988.

Articles

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3. Sullivan D. Model for comprehensive systematic program development in health education. *Health Education Reports* 1973; 1(1): 4-5.
4. Cochran LH, Phelps LA, Cochran LL. *Advisory committees in action*. Boston: Allyn and Bacon, 1980.
5. Division of Maternal and Child Health. *Healthy mothers, healthy babies: the community connection* (2nd ed.). Washington, DC: US Public Health Service, 1986.
6. Haffner DW. The AIDS epidemic: implications for the sexuality of our youth. *SEICUS Reports* 1988; 16(6): 2-3.
7. Allensworth DD, Symons C. A theoretical approach to school-based HIV prevention. *Journal of School Health* 1989; 59: 59-65.
8. Kumpfer, KL. Prevention of alcohol and drug abuse: a critical review of risk factors and prevention strategies. In Shaffer MB, Philips I, and Enzer NB (eds.): *OSAP prevention monograph-2, prevention of mental disorders, alcohol and other drug use in children and adolescents*. Rockville, MD: Office for Substance Abuse Prevention, 1989.
9. Center for Population Options. *Teens' Survey of Stores in the District of Columbia on Accessibility of Family Planning Methods*, Unpublished manuscript, 1988.
10. American Nurses Association. *Personal heroism, professional activism: nursing and the battle against AIDS*. Kansas City, MO: American Nurses Association, 1988.
11. National School Boards Association. *Resolutions of the National School Boards Association*. *School Board News*, 1989;(11): 6 (insert).
12. Keough KE. *Dealing with AIDS: breaking the chain of infection*. Arlington, VA: American Association of School Administrators, 1988.
13. Haffner DW. *AIDS and adolescents: the time for prevention is now*. Washington, DC: Center for Population Options, 1987.
14. Center for Population Options. *Adolescents, AIDS and HIV a community-wide responsibility*. Washington, DC: Center for Population Options, 1989.
15. Vincent ML, Clearie AF, Schluchter MD. Reducing adolescent pregnancy through school and community based education. *Journal of the American Medical Association* 1987; 257: 3382-6.
16. Bartlett EG. The contribution of school health to community health promotion: what can we reasonably expect? *American Journal of Public Health* 1981; 71: 1384-91.
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Chapter 4:

Peer Education Approaches to HIV Education

Although school-based HIV infection prevention interventions are aimed at students, most strategies and principles this manual has examined thus far have not involved students themselves as HIV educators. For the HIV infection prevention message to be readily heeded by adolescents, adolescents must be used to disseminate the message. Haffner contends that teenagers are the major source of health-related information for their peers¹. Teens have a unique understanding of what is occurring in their world; they have firsthand knowledge of their social groups and the pressures they face in today's society. For those reasons, student participation in HIV prevention programs should go beyond passive acceptance of information from adults—teens should be actively involved in education and outreach. Peer influence is powerful and can be used constructively to effect positive behaviors among students and help prevent HIV infection.

The terms "peer education" and "peer counseling" are frequently used interchangeably. Peer educators often respond to value-laden issues and concerns, especially when they are working one-to-one with other students. In this sense they are "counselors", but it is important that they learn when and how to refer students to outside agencies for assistance with counseling or therapy².

Peer instruction and counseling have been used in many health-related programs and appear to be of value for influencing teen health practices that relate to the prevention of HIV infection. For example, in a pretest and posttest of knowledge, attitudes, and behavioral intent, teens in one peer HIV program had corrected their misinformation about HIV and AIDS and stated that they would take greater precautions to protect themselves from HIV infection³.

Activities appropriate for peer educators are unlimited. Trained students may address classes and community youth groups, staff "rap rooms" where other students can drop in and discuss HIV-related concerns, and maintain telephone hotlines offering referral and empathic listening. Role-modeling and peer support systems are additional benefits of peer counseling and education programs³.

Besides peer education, students also should be actively involved in HIV education curricula selection and design and in any other plans for intervention and service. Teens can generally judge which intervention methods will succeed and which will fail. To provide students successful interventions, the perceived needs of students first must be identified and then met if behavior change is the goal.

Steps for Initiating a Peer Education Program

The following steps have been recommended for initiating a peer education program in the high school setting:

- Elicit support from school administrators, teachers, staff, parents, community groups, and students.
- Recruit and select students to serve as peer educators.
- Conduct the training program.
- Implement the program.
- Evaluate the success of the program¹.

Elicit Support

Administrative approval of the peer education program is a necessary first step. A proposal for the program should be developed and presented to administrators. Pending approval, the program should be presented at a faculty meeting. Teachers should be informed about the program so that they may recommend students as peer counselors. If a presentation at a faculty meeting is not possible, faculty may be approached individually to assist with the program¹.

School/community interaction is a primary component of the multidisciplinary approach to prevention and contributes to quality peer education programs. Community support can enhance the effectiveness of the program through shared resources and expertise and sometimes provide funding to continue programming. A local AIDS Task Force, an American Red Cross Chapter, a health department, or local businesses may be solicited for involvement in, or support of, the program. Efforts to involve parents are beneficial and contribute to acceptance of the program.

Finally, student support of the program is imperative. The multiple channels of the school should be used to provide information about the program (e.g., announcements in classes and over school public address systems, posters on school bulletin boards, notices in the school newspaper). Personal, word-of-mouth promotions appear to be the most effective method of soliciting student involvement².

At some time before the training is implemented, program planners must decide whether or not to pay peer educators. This is a controversial issue: some feel that the students deserve to be compensated for their work; others feel that payment may lead some students to do this work "just for the money." Local policies and potential funding sources should also be considered before this decision is made².

Recruit and Select Students

Some peer education programs provide specific criteria for student selection and ask faculty and staff to make recommendations based upon these criteria. One school system required that students be sophomores or juniors, humanistic, friendly, empathetic, responsible, mature, and socially skilled, and have a strong sense of personal identity and leadership potential, adequate time for involvement in the project, and an interest in helping others. A handout of these characteristics was prepared and given to each professional staff member at the school so that they could recommend students¹.

This process of active recruitment is common; on the other hand, no student can be required to participate. It is suggested that "leaders" be recruited; that is, not only should academic achievers be considered but also those who are popular and those who have athletic ability². All segments of the school be represented. One advantage of recruitment is that it bolsters the self-esteem of the recruited students, even if they choose not to participate in the program⁴.

After a sufficient number of students have been recruited, an orientation meeting should be conducted. This meeting can both provide information about the program and assess the motivational level of the potential peer educators¹. As a follow-up to the meeting, the program coordinator may elect to send introductory letters to parents, both to describe the program and to indicate their child's interest in participating. Inviting parents to review the program and ask questions about it can allay their fears and apprehension and consequently engender their support².

Conduct the Training Program

The Center for Population Options (CPO) recommends a three-component training model for HIV and AIDS:

- Provide a strong factual base of information on transmission, infection, and prevention.
- Assist peer educators with self-exploration and clarification of values regarding sexuality, sexual orientation, drug use, and other HIV-related issues.
- Enhance decision-making and communication skills via experiential, interactive activities such as role playing².

CPO strongly recommends the involvement of PWA's in training sessions to develop a compassionate response among peer educators. Interacting with a PWA also makes the threat of HIV infection more real to teens by putting a human face on the disease².

Other training programs involve topics such as cultural sensitivity, sex education/birth control/STD's, substance use, modeling of peer education techniques, building self-esteem, role playing, communication skills, and educational strategies³.

Implement the Program

A peer education program is implemented according to the type of program and its goals; for example, the implementation of a telephone hotline service would be very different from that of a drop-in center. Proper location and hours of operation for the peer education and counseling service is critical. For example, a drop-in center should be located at a site that assures confidentiality of clients. One school located the drop-in center in a small storage room

that opened off a lobby adjacent to the school cafeteria. The peer counselors had few clients—apparently because few students were willing to be seen using this "confidential" service¹. In addition, hours of operation of the drop-in center must be conducive to student schedules.

Another common activity of peer education groups is to present information about AIDS and HIV infection to community groups, including church and youth groups, and to junior and senior high school students. To implement this type of program, efficient scheduling of presentations is paramount, and a core of adequately trained peer educators as well as substitutes is necessary. It may be necessary to periodically excuse the peer educators from school to make presentations at neighboring schools. The peer group advisor or program director should obtain approval for these activities from school administrators. Peer educators need to inform teachers of absences for program presentations and ensure that class work missed because of such presentations is made up in a timely fashion.

Evaluate the Success of the Program

Evaluations should be conducted to determine the effectiveness of peer education programs. Programs deemed effective by such evaluations are more likely to receive future funding.

Peer education programs are evaluated both quantitatively and qualitatively. The following criteria are often used:

- Achievement of program goals and objectives as measured by the number of youth reached, or completion of specific program components by a target date.
- Types and amounts of materials distributed.
- Reactions to, and suggested changes in, the program.
- Pretests and posttests of knowledge, attitudes, and behavioral intent of the peer educators as well as the students they are serving².

Model Programs for Peer Education/Counseling

Innovative efforts to integrate HIV education into school-based peer education programs have been initiated. One of the first programs, pioneered in 1986, uses a teen speakers bureau to conduct presentations to peers in schools and community settings in Maryland and Washington, D.C. An outgrowth of the program is a telephone hotline staffed by teens who have access to a computer programed with frequently asked questions and answers about AIDS. Teen staffers are paid an hourly wage³.

A San Francisco Unified School District peer education program including HIV education has been recognized as a model effort. The district has added more than 30 hours of HIV and STD education to its existing training program. Peer counselors teach in the classroom and provide individual counseling, and the program uses peer role models, language relevant to teens, and realistic problem solving⁶.

In Washington, D.C., CPO has initiated Teens for AIDS Prevention (TAP). TAP's primary goals are to identify the HIV knowledge base and attitudes of inner-city youth as a starting point for effective prevention strategies and to develop and evaluate a peer-mediated approach that succeeds in changing teens' attitudes and behaviors related

to sex, drugs, and other health risks².

TAP chapters have been formed at two of the city's senior high schools. Some 24 teen educators, who have received extensive education about HIV, have designed schoolwide activities such as developing media (posters, buttons, pamphlets, newspaper ads, and stickers), conducting presentations for classes and outside groups, and sponsoring contests, rap music compositions, skits, and student rallies².

CPO plans to use TAP as a model for schools nationwide. For more information about the program, contact the Center for Population Options, 1012 14th Street, N.W., Suite 1200, Washington, D.C. 20005.

Teens Against AIDS is a grassroots, community-based peer education program under way in Raleigh, North Carolina. The program primarily targets local black youth aged 12 to 18, although children as young as age nine have been involved. Its objectives include preventing HIV infection in adolescents and altering misconceptions about AIDS within the black community. Peer educators for this program are drawn from two populations of black teens. Half the peer educators fit the criteria for children at risk for dropping out of school—they are socioeconomically disadvantaged, live in housing projects, and have a history of school failure or behavior problems. The other peer educators come from middle- to high-income families and are performing at above-average levels in school. Students work about five hours a week and are paid \$4 an hour³.

The Medical Foundation of Boston launched its Peer Leadership/Preventing AIDS program in January 1988. It uses peer educators to provide AIDS and HIV information to teen audiences in Boston schools. The training of teen educators focuses on building self-esteem, on decision making, and on communication skills such as active listening⁴.

The Rhode Island Department of Education Peer Education Program has subcontracted with two community agencies to conduct outreach programs for out-of-school youth. The contract funded staff positions in the agencies for training peer educators and provided stipends for the trained peer educators. The program was developed to recruit and train as AIDS peer educators a group of 15 to 20 teens from various socioeconomic backgrounds, ethnic groups, and sexual orientations. As a result of this project, 15 peer educators have contacted 4,000 youth in street outreach activities such as distributing literature and condoms to people at beaches, concerts, etc. In addition, 750 personnel and/or clients of 8 community agencies have received HIV education from the peer educators⁵.

Resources for Peer Education

Videotapes, films, and other educational resources incorporating peer education techniques are available from several sources. The following videotapes use a peer education format:

Choices: Learning About AIDS, National Safety Council, 444 North Michigan Avenue, Chicago, IL 60611, (312) 526-4800. Note: The video is part of an educational package on AIDS that includes a teacher's guide, administrator's guide, student booklet, and parent's booklet.

Sex, Drugs and AIDS, O.D.N. Productions, Inc., 74 Varick Street, Suite 304, New York, NY 10013, (212) 431-8923.

All of Us and AIDS, New Day Films, ETR Associates, P.O. Box 1830, Santa Cruz, CA 95061-1830, (408) 438-4080.

A book that assists with peer education programs is *Peer Education: Teens Teaching Teens About AIDS and HIV Infection Prevention*. It is available from the Center for Population Options, 1012 14th Street, NW, Suite 1200, Washington, DC 20005.

Another helpful resource is *Adolescent Peer Pressure: Theory, Correlates, and Program Implications for Drug Abuse Prevention*. This publication of the U.S. Department of Health and Human Services is available from the Office for Substance Abuse Prevention, 5600 Fishers Lane, Rockville, Maryland 20857. Although the book's title suggests a specialization in drug abuse, many featured programs address other issues that are easily adapted to HIV prevention.

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Chapter 5

Student Skills for the Prevention of HIV Infection

Adolescents need both knowledge and skills to help them practice behaviors that prevent HIV infection. Knowledge of the virus, its transmission, and its prevention are essential but not sufficient to deter practices that might lead to infection with HIV. The etiology of most behaviors—and in particular of sexual behaviors—is multifactorial. Students trying to adopt health-enhancing behaviors need specific skills in decision making, problem solving, refusal, communication, and assertiveness.

Decision Making

Decision making and problem solving are two of the most important skills students can learn through health education classes¹. Learning and practicing these skills enables students in difficult situations to think before they act. Opinions vary about the appropriate grade level to begin decision making training, but many educators believe youth should demonstrate this skill by the time they enter junior high school². Many school systems, however, never teach students the decision-making process.

Decision making is a critical component of HIV education for adolescents. Meeks and Heit apply what they refer to as a responsible decision-making approach in their curriculum *AIDS: What You Should Know*³. Their decision-making process calls for students to do the following:

- Identify the situation.
- Identify different decisions one might make to resolve the situation. (There may be more than one responsible way to resolve the situation.)
- Ask questions about each possible decision. Students may ask themselves five questions to assess whether a proposed decision will lead to responsible actions. "Would the results of my decision be healthful?" "Would the results of my decision be safe?" "Would the results of my decision be legal?" "Would the results of my decision show respect for myself and others?" "Would the results of my decision follow my parent's or guardian's guidelines?"
- Make a responsible decision and act on it after answering the five questions in Step 3.
- Evaluate actions. Use the five questions in Step 3 to review the decision and to confirm that it was responsible.

Other decision-making models employ similar steps without introducing the five questions in Step 3. For example, CPO's curriculum *Life Planning Education: A Youth Development Program* lists the following steps in its decision-making model:

- Name the choices or alternatives involved in your decision.
- Gather information about the decision. (Consider your personal values and goals and list what facts you need to know.)
- List the advantages and disadvantages of each choice.
- Make your decision and list your reasons for this choice⁴.

A variety of activity worksheets are included in this curriculum, which also includes activities for refusal skills and developing assertiveness. For more information, contact the Center for Population Options, 1025 Vermont Avenue, NW, Suite 210, Washington, D.C. 20005; (202) 347-5700.

Students can benefit greatly from practicing decision-making skills. Sample situations related to HIV transmission can be used for in-class practice. Students may also apply the decision-making model to scenarios they have created. Examples of HIV-related topics that could be raised include deciding whether to abstain from sexual intercourse, how to involve parents in decisions, whether to use condoms when having sex, whether to use alcohol and/or other drugs, and whether to seek counseling and testing for HIV infection and other STDs.

Students should be encouraged to involve their parents when making critical decisions. Schools have a responsibility to facilitate parent/student interaction. The health instructional program should include information about involving parents in decision making. Role plays should include parent characters. The local PTA could sponsor a parent-child communication night or provide sessions on "How to talk to your child or teenager about AIDS". More information on parental involvement with HIV education and resources for parents can be found in the "Parents' Role" section of Chapter Three (pages 31-32).

Problem Solving

Problem solving is often discussed in conjunction with decision making. To solve a problem, one must employ decision-making skills. Developing personal decision-making and problem-solving abilities of students is a primary goal of education⁵.

To encourage reflective thinking among students about STDs, HIV infection, pregnancy prevention, drug abuse, and other topics, educators may pose questions, such as those listed below, in order to generate discussion:

- Where can students obtain information about sexually transmitted diseases?

- How can students learn about their parents' values and concerns and incorporate them when making personal decisions?
- If students are sexually active, how can they protect themselves and their partners from pregnancy, STDs, and HIV infection?
- Who can help students gain information about contraceptives?
- What should students do if they believe they may have been infected with an STD or HIV?

From such exercises, students gain vicarious experience in dealing with problematic situations before they occur. By thinking through different options, students in a critical situation may be less likely to choose the first solution that comes to mind. Problem-solving exercises teach students to act only after considering alternative behaviors and probable consequences of their actions.

In regard to HIV infection, these skills can save lives. Knowing the perils of HIV infection, students may think twice before engaging in high-risk behaviors. For example, students who feel pressured to have unprotected sex may weigh the alternatives—abstinence, applying assertiveness and refusal skills, or using a condom. They may consider possible negative consequences such as pregnancy, STDs, and/or HIV infection.

Successful decision-making and problem-solving instruction is predicated on youth recognizing their vulnerability as well as their ability to protect their health. Lessons should include activities encouraging students to confront their vulnerability and mortality. Such experience empowers students to take charge of their lives and make responsible and healthful decisions.

Refusal Skills

Familiarity with a systematic method of problem solving may enable students to more effectively solve their personal problems. Especially for youth, the desire or pressure to conform to peers' actions and choices may present a challenge to those who choose to pursue unpopular, but health-enhancing, alternatives. Refusal skills enable youth to stick by their decisions to avoid specific behaviors, even in the face of peer disapproval. Educators play an important role in developing these skills by providing instruction about them and class time for their practice.

Meeks and Heit suggest that student refusal skills include these actions:

- 1) Giving reasons why saying no is a responsible choice.
- 2) Using their behavior to show they mean what they say. (For instance, they should avoid being alone with peers who try to convince them to be sexually active.)
- 3) Encouraging others to choose healthful and responsible behaviors.
- 4) Using self-control and sticking to their decision. (Self-control is the ability to make responsible decisions and choose responsible behaviors that will promote health.)
- 5) Removing themselves from hazardous situations¹. The Meeks and Heit manuals *AIDS: What You Should Know, Grades 5-8* and *AIDS: Understanding and Prevention, High School* are available from Glencoe Publishers, 936 Eastwind Drive, Westerville, OH 43081, (614) 890-1111.

In the middle school curriculum *Preventing AIDS*, the Education Development Center, Inc. (EDC) provides possible strategies for students to use when "saying no." These include the following:

- Say "I just don't want to" plain and simple.
- Broken record—keep saying "no" over and over.
- Delay the decision—"Maybe some other time."
- Make your parents the bad guys—"They're coming to pick me up soon" or "They watch me like a hawk."
- Leave the situation—"I'm going."
- Reverse the pressure—"If you loved me, you wouldn't pressure me"⁶.

In this curriculum, EDC also includes the handout "Twenty Ways to Say No to Sexual Involvement" and describes role-playing situations for decision making, refusal skills, and problem solving. For more information about these resources, contact the Education Development Center, Inc., 55 Chapel Street, Newton, MA 02160, (800) 225-4276.

Sroka and Calabrese have incorporated refusal and decision-making skills into their curriculum *Educator's Guide to AIDS and Other STD's*. A section of the book, titled "STD Prevention Strategies," includes the worksheets "Preparing Saying No Skills" and "Practicing Saying No Skills." For more information, contact Steven R. Sroka, Ph.D., Inc., Health Education Consultants, 1284 Manor Park, Lakewood, OH 44107, (216) 521-1766.

In their book *Into Adolescence: Coping with Sexual Pressures*, Abbey and Picco include a worksheet entitled "Saying No," which is designed for parents and students to complete together⁷. Parental involvement in HIV education is recommended throughout this manual. Such involvement helps to reinforce critical HIV infection prevention messages. This book is available from: Network Publications, P.O. Box 1830, Santa Cruz, CA 95061-1830, (800) 321-4407.

A healthy self-concept is essential to the development of refusal skills. A healthy self-concept promotes feelings of self-worth and control—characteristics that are necessary to pursue an individual choice, especially if it is different or unpopular. School-based professionals should place a high priority on assisting students to develop a positive self-concept. (Additional information about this topic was provided on page 9.)

Communication Skills

Effective communication, an essential skill for adolescents, can positively influence their health behavior, self-esteem, and interpersonal relationships⁸. Active listening and other effective communication skills should be taught to students. Active listening skills include the following:

- Making eye contact with the person who is speaking.
- Nodding or changing facial expressions to show interest in what the speaker is saying.
- Paraphrasing, asking questions, or making comments about what has been said.

As part of the multidisciplinary approach, English, foreign language, or speech educators can reinforce these skills in their classes. Students may be paired off in partners to practice active listening skills or in groups of three where two partners converse and one acts as the observer. At the close of the conversation, the observer discusses the

listening and communication skills of the partners.

It is important for students to learn that effective communication should be a two-way interaction. The following exercise helps to show students the importance of effective two-way communication.

Communication Exercise

Have partners stand back-to-back. Give one a simple drawing (e.g., one of geometrical figures such as squares, triangles, circles, and rectangles leaning against each other at different angles). Have the partner with the drawing describe it to the other partner, who is not permitted to ask any questions but must attempt to draw the figure. When the drawing is finished, partners should compare their drawings. Then they should find another partner and repeat the exercise but this time allow the "artist" partner to ask questions about the description. The final drawing should be more accurate than the first.

Education about communication should include nonverbal as well as verbal aspects. Assistance in understanding assertive, aggressive, and nonassertive communication, as well as various language systems such as street language or cultural variations in language should be discussed⁹.

Communicating about sexuality can be especially difficult. Discussing why it is hard to talk about sex is often a good starting point for those having difficulty with sexual communication. At first, discussing nonthreatening sexuality topics is preferable. The next step may be to discuss previous experiences with attempts at sexual communication. This step has been called "talking about talking"¹⁰. Discussion of what happened when you attempted to talk to parents, friends, teachers, and others about sexuality topics may prove to be productive as well¹⁰.

Reading and discussing is another technique that is often used. Students or persons interested in communicating about sexuality may read articles about sexuality topics or chapters of sexuality books and then discuss these readings together. They may then compare their reactions to the readings¹⁰.

The use of open-ended questions is a particularly effective communication technique. These are preferable to "yes or no" questions because they encourage discussion. For example, it would be more effective to ask a partner the open-ended question "How do you feel about using condoms?" than the close-ended question "Will you use a condom?" when communicating about this issue. Whereas close-ended questions call for a "yes" or "no" answer and thus reveal little about the person answering, open-ended questions encourage that person to share any thoughts he or she may have on the issue¹⁰.

Assertiveness

Assertiveness has been defined as the ability to stand up for one's rights without violating the rights of others and to stand up for oneself without undue anxiety¹¹. With regard to HIV education, adolescents would benefit from learning assertiveness skills so that they may provide such responses when tempted with unwanted sexual or drug use advances. Assertive responses are not hurtful to others; unlike

aggressive responses, they do not violate other's rights⁹.

Instruments have been developed to measure student assertiveness¹². Through the use of such instruments, students may determine their personal assertiveness levels. Those with low assertiveness scores can be taught assertiveness skills and by participating in role-playing situations such as the ones below can practice these skills.

Assertive behavior includes the following:

- Sitting or standing tall and looking directly at the person to whom you are speaking.
- Making gestures or appropriate physical contact if one is comfortable with such contact.
- The use of "I" statements (e.g., I feel, I need, I believe) in which the communicator expresses his or her feelings rather than blaming the other person with "you" statements.
- An insistence that the other party hear one out⁹.

Assertiveness may be used along with refusal skills to decline a sexual or drug use advance by another. Stating one's own desires and needs requires assertive communication. In our culture, because of our socialization process, many females find it particularly difficult to assert themselves. Educators may provide practice sessions to develop these student skills by using general role playing situations such as the following:

Situation 1

You are out at a restaurant and order a salad with Italian dressing. The server brings you a salad with blue cheese dressing, which you hate. Role play what you would say and do with a partner who is playing the server.

Situation 2

At a department store, you have paid for something with a twenty dollar bill. The cashier gives you change for a ten dollar bill. Role play what you would say and do with a partner who is playing the cashier.

Educators may provide more sexually specific role playing situations such as the following:

Situation 3

Your date, in trying to convince you to have sex, tells you that all your friends are having it and that you should too if you really love him/her. You have decided to be abstinent but have had several beers. Role play what you would say and do with a partner who is playing your date.

Situation 4

You are becoming intimate with someone you have dated for a long time. You have decided that you will have sex only if your male partner uses a condom and spermicide. When you tell him this, he says he will not use them. Role play what you would say and do.

Situation 5

You are in the school weightlifting club. A championship meet is coming up soon, and today you are working out with last year's champion. Before the workout you see him in the locker room, injecting something into his arm. When you ask what he is doing, he says he is using steroids, which build muscle mass. He says they helped him win the championship last year and asks you if you want some. Role play what you would say and do in this situation.

Educators can involve the rest of the class by having them observe partner interactions. The class can then discuss whether the responses they observed in the role plays were assertive, aggressive or nonassertive. In situation

3, the educator could initiate discussion on how alcohol may affect the decision-making process. In situation 5, a discussion about steroid use could occur.

Additional activities addressing assertiveness and communication are available in the curriculum *Life Planning Education: A Youth Development Program*. This book is available from: The Center for Population Options, 1025 Vermont Avenue, NW, Suite 210, Washington, D.C. 20005, (202) 347-5700.

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Appendix A

CDC Guidelines for Effective School Health Education to Prevent the Spread of AIDS

Centers for Disease Control
Morbidity and Mortality Weekly Report Supplement
January 29, 1988/Vol. 37/No. S-2

Guidelines for Effective School Health Education to Prevent the Spread of AIDS

U.S. Department of Health and Human Services
Public Health Service
Centers for Disease Control
Center for Health Promotion and Education
Atlanta, Georgia 30333

Introduction

Since the first cases of acquired immunodeficiency syndrome (AIDS) were reported in the United States in 1981, the human immunodeficiency virus (HIV) that causes AIDS and other HIV-related diseases has precipitated an epidemic unprecedented in modern history. Because the virus is transmitted almost exclusively by behavior that individuals can modify, educational programs to influence relevant behavior can be effective in preventing the spread of HIV (1-5).

The guidelines below have been developed to help school personnel and others plan, implement, and evaluate educational efforts to prevent unnecessary morbidity and mortality associated with AIDS and other HIV-related illnesses. The guidelines incorporate principles for AIDS education that were developed by the President's Domestic Policy Council and approved by the President in 1987 (see Appendix I).

The guidelines provide information that should be considered by persons who are responsible for planning and implementing appropriate and effective strategies to teach young people about how to avoid HIV infection. These guidelines should not be construed as rules, but rather as a source of guidance. Although they specifically were developed to help **school personnel**, personnel from other organizations should consider these guidelines in planning and carrying out effective education about AIDS for youth who do **not** attend school and who may be at high risk of becoming infected. As they deliberate about the need for and content of AIDS education, educators, parents, and other concerned members of the community should consider the prevalence of behavior that increases the risk of HIV infection among young people in their communities. Information about the nature of the AIDS epidemic, and the extent to which young people engage in behavior that increases the risk of HIV infection, is presented in Appendix II.

Information contained in this document was developed by CDC in consultation with individuals appointed to represent the following organizations:

American Academy of Pediatrics
American Association of School Administrators
American Public Health Association
American School Health Association

Association for the Advancement of Health Education
Association of State and Territorial Health Officers
Council of Chief State School Officers
National Congress of Parents and Teachers
National Council of Churches
National Education Association
National School Boards Association
Society of State Directors of Health, Physical
Education, Recreation and Dance

U.S. Department of Education
U.S. Food and Drug Administration
U.S. Office of Disease Prevention and Health Promotion
Consultants included a director of health education for a state department of education, a director of curriculum and instruction for a local education department, a health education teacher, a director of school health programs for a local school district, a director of a state health department, a deputy director of a local health department, and an expert in child and adolescent development.

Planning and Implementing Effective School Health Education about AIDS

The Nation's public and private schools have the capacity and responsibility to help assure that young people understand the nature of the AIDS epidemic and the specific actions they can take to prevent HIV infection, especially during their adolescence and young adulthood. The specific scope and content of AIDS education in schools should be locally determined and should be consistent with parental and community values.

Because AIDS is a fatal disease and because educating young people about becoming infected through sexual contact can be controversial, school systems should obtain broad community participation to ensure that school health education policies and programs to prevent the spread of AIDS are locally determined and are consistent with community values.

The development of school district policies on AIDS education can be an important first step in developing an AIDS education program. In each community, representatives of the school board, parents, school administrators and faculty, school health services, local medical societies, the local health department, students, minority groups, religious organizations, and other relevant organizations can be involved in developing policies for school health education to prevent the spread of AIDS. The process of policy development can enable these representatives to resolve various perspectives and opinions, to establish a commitment for implementing and maintaining AIDS education programs, and to establish standards for AIDS education program activities and materials. Many communities already have school health councils that include representatives from the aforementioned groups. Such councils facilitate the development of a broad base of community expertise and input, and they enhance the coordination of various

activities within the comprehensive school health program⁶.

AIDS education programs should be developed to address the needs and the developmental levels of students and of school-age youth who do not attend school, and to address specific needs of minorities, persons for whom English is not the primary language, and persons with visual or hearing impairments or other learning disabilities. Plans for addressing students' questions or concerns about AIDS at the early elementary grades, as well as for providing effective school health education about AIDS at each grade from late elementary/middle school through junior high/senior high school, including educational materials to be used, should be reviewed by representatives of the school board, appropriate school administrators, teachers, and parents before being implemented.

Education about AIDS may be most appropriate and effective when carried out within a more comprehensive school health education program that establishes a foundation for understanding the relationships between personal behavior and health⁷. For example, education about AIDS may be more effective when students at appropriate ages are more knowledgeable about sexually transmitted diseases, drug abuse, and community health. It may also have greater impact when they have opportunities to develop such qualities as decision-making and communication skills, resistance to persuasion, and a sense of self-efficacy and self-esteem. However, education about AIDS should be provided as rapidly as possible, even if it is taught initially as a separate subject. State departments of education and health should work together to help local departments of education and health throughout the state collaboratively accomplish effective school health education about AIDS. Although all schools in a state should provide effective education about AIDS, priority should be given to areas with the highest reported incidence of AIDS cases.

Preparation of Education Personnel

A team of representatives including the local school board, parent-teacher associations, school administrators, school physicians, school nurses, teachers, educational support personnel, school counselors, and other relevant school personnel should receive general training about a) the nature of the AIDS epidemic and means of controlling its spread, b) the role of the school in providing education to prevent transmission of HIV, c) methods and materials to accomplish effective programs of school health education about AIDS, and d) school policies for students and staff who may be infected. In addition, a team of school personnel responsible for teaching about AIDS should receive more specific training about AIDS education. All school personnel, especially those who teach about AIDS, periodically should receive continuing education about AIDS to assure that they have the most current information about means of controlling the epidemic, including up-to-date information about the most effective health education interventions available. State and local departments of education and health, as well as colleges of education, should assure that such in-service training is made available to all schools in the state as soon as possible and that continuing in-service and preservice training is subsequently provided. The local school board should assure that release time is provided to enable school personnel to receive such in-service training.

Programs Taught by Qualified Teachers

In the elementary grades, students generally have one regular classroom teacher. In these grades, education about AIDS should be provided by the regular classroom teacher because that person ideally should be trained and experienced in child development, age-appropriate teaching methods, child health, and elementary health education methods and materials. In addition, the elementary teacher usually is sensitive to normal variations in child development and aptitudes within a class. In the secondary grades, students generally have a different teacher for each subject. In these grades, the secondary school health education teacher

preferably should provide education about AIDS, because a qualified health education teacher will have training and experience in adolescent development, age-appropriate teaching methods, adolescent health, and secondary school health education methods and materials (including methods and materials for teaching about such topics as human sexuality, communicable diseases, and drug abuse). In secondary schools that do not have a qualified health education teacher, faculty with similar training and good rapport with students should be trained specifically to provide effective AIDS education.

Purpose of Effective Education about AIDS

The principal purpose of education about AIDS is to prevent HIV infection. The content of AIDS education should be developed with the active involvement of parents and should address the broad range of behavior exhibited by young people. Educational programs should assure that young people acquire the knowledge and skills they will need to adopt and maintain types of behavior that virtually eliminate their risk of becoming infected.

School systems should make programs available that will enable and encourage young people who *have not* engaged in sexual intercourse and who *have not* used illicit drugs to continue to-

- Abstain from sexual intercourse until they are ready to establish a mutually monogamous relationship within the context of marriage;
 - Refrain from using or injecting illicit drugs.
- For young people who *have* engaged in sexual intercourse or who *have* injected illicit drugs, school programs should enable and encourage them to-
- Stop engaging in sexual intercourse until they are ready to establish a mutually monogamous relationship within the context of marriage;
 - To stop using or injecting illicit drugs.

Despite all efforts, some young people may remain unwilling to adopt behavior that would virtually eliminate their risk of becoming infected. Therefore, school systems, in consultation with parents and health officials, should provide AIDS education programs that address preventive types of behavior that should be practiced by persons with an increased risk of acquiring HIV infection. These include:

- Avoiding sexual intercourse with anyone who is known to be infected, who is at risk of being infected, or whose HIV infection status is not known;
- Using a latex condom with spermicide if they engage in sexual intercourse;
- Seeking treatment if addicted to illicit drugs;
- Not sharing needles or other injection equipment;
- Seeking HIV counseling and testing if HIV infection is suspected.

State and local education and health agencies should work together to assess the prevalence of these types of risk behavior, and their determinants, over time.

Content

Although information about the biology of the AIDS virus, the signs and symptoms of AIDS, and the social and economic costs of the epidemic might be of interest, such information is not the essential knowledge that students must acquire in order to prevent becoming infected with HIV. Similarly, a single film, lecture, or school assembly about AIDS will not be sufficient to assure that students develop the complex understanding and skills they will need to avoid becoming infected.

Schools should assure that students receive at least the essential information about AIDS, as summarized in sequence in the following pages, for each of three grade-level ranges. The exact grades at which students receive this essential information should be determined locally, in accord with community and parental values, and thus may vary from community to community. Because

essential information for students at higher grades requires an understanding of information essential for students at lower grades, secondary school personnel will need to assure that students understand basic concepts before teaching more advanced information. Schools simultaneously should assure that students have opportunities to learn about emotional and social factors that influence types of behavior associated with HIV transmission.

Early Elementary School

Education about AIDS for students in early elementary grades principally should be designed to allay excessive fears of the epidemic and of becoming infected.

AIDS is a disease that is causing some adults to get very sick, but it does not commonly affect children.

AIDS is very hard to get. You cannot get it just by being near or touching someone who has it.

Scientists all over the world are working hard to find a way to stop people from getting AIDS and to cure those who have it.

Late Elementary/Middle School

Education about AIDS for students in late elementary/middle school grades should be designed with consideration for the following information.

Viruses are living organisms too small to be seen by the unaided eye.

Viruses can be transmitted from an infected person to an uninfected person through various means.

Some viruses cause disease among people.

Persons who are infected with some viruses that cause disease may not have any signs or symptoms of disease.

AIDS (an abbreviation for acquired immunodeficiency sndrome) is caused by a virus that weakens the ability of infected individuals to fight off disease.

People who have AIDS often develop a rare type of severe pneumonia, a cancer called Kaposi's sarcoma, and certain other diseases that healthy people normally do not get.

About 1 to 1.5 million of the total population of approximately 240 million Americans currently are infected with the AIDS virus and consequently are capable of infecting others.

People who are infected with the AIDS virus live in every state in the United States and in most other countries of the world. Infected people live in cities as well as in suburbs, small towns, and rural areas. Although most infected people are adults, teenagers can also become infected. Females as well as males are infected. People of every race are infected, including whites, blacks, Hispanics, Native Americans, and Asian/Pacific Islanders.

The AIDS virus can be transmitted by sexual contact with an infected person; by using needles and other injection equipment that an infected person has used; and from an infected mother to her infant before or during birth.

A small number of doctors, nurses, and other medical personnel have been infected when they were directly exposed to infected blood.

It sometimes takes several years after becoming infected with the AIDS virus before symptoms of the disease appear. Thus, people who are infected with the virus can infect other people—even though the people who transmit the infection do not feel or look sick.

Most infected people who develop symptoms of AIDS only live about 2 years after their symptoms are diagnosed.

The AIDS virus cannot be caught by touching someone who is infected, by being in the same room with an infected person, or by donating blood.

Junior High/Senior High School

Education about AIDS for students in junior high/senior high school grades should be developed and presented taking into consideration the following information.

The virus that causes AIDS, and other health problems, is called Human Immunodeficiency Virus, or HIV.

The risk of becoming infected with HIV can be virtually eliminated by not engaging in sexual activities and by not using illegal intravenous drugs.

Sexual transmission of HIV is not a threat to those uninfected individuals who engage in mutually monogamous sexual relations.

HIV may be transmitted in any of the following ways: a) by sexual contact with an infected person (penis/vagina, penis/rectum, mouth/vagina, mouth/penis, mouth/rectum); b) by using needles or other injection equipment that an infected person has used; c) from an infected mother to her infant before or during birth.

A small number of doctors, nurses, and other medical personnel have been infected when they were directly exposed to infected blood.

The following are at increased risk of having the virus that causes AIDS and consequently of being infectious: a) persons with clinical or laboratory evidence of infection; b) males who have had sexual intercourse with other males; c) persons who have injected illegal drugs; d) persons who have had numerous sexual partners, including male or female prostitutes; e) persons who received blood clotting products before 1985; f) sex partners of infected persons or persons at increased risk; and g) infants born to infected mothers.

The risk of becoming infected is increased by having a sexual partner who is at increased risk of having contracted the AIDS virus (as identified previously), practicing sexual behavior that results in the exchange of body fluids (i.e., semen, vaginal secretions, blood), and using unsterile needles or paraphernalia to inject drugs. Although no transmission from deep, open-mouth (i.e., "French") kissing has been documented, such kissing theoretically could transmit HIV from an infected to an uninfected person through direct exposure of mucous membranes to infected blood or saliva.

In the past, medical use of blood, such as transfusing blood and treating hemophiliacs with blood clotting products, has caused some people to become infected with HIV. However, since 1985 all donated blood has been tested to determine whether it is infected with HIV, moreover, all blood clotting products have been made from screened plasma and have been heated to destroy any HIV that might remain in the concentrate. Thus, the risk of becoming infected with HIV from blood transfusions and from blood clotting products is virtually eliminated. Cases of HIV infection caused by these medical uses of blood will continue to be diagnosed, however, among people who were infected by these means before 1985.

Persons who continue to engage in sexual intercourse with persons who are at increased risk or whose infection status is unknown should use a latex condom (not natural membrane) to reduce the likelihood of becoming infected. The latex condom must be applied properly and used from start to finish for every sexual act. Although a latex condom does not provide 100% protection because it is

possible for the condom to leak, break, or slip off-it provides the best protection for people who do not maintain a mutually monogamous relationship with an uninfected partner. Additional protection may be obtained by using spermicides that seem active against HIV and other sexually transmitted organisms in conjunction with condoms.

Behavior that prevents exposure to HIV also may prevent unintended pregnancies and exposure to the organisms that cause Chlamydia infection, gonorrhea, herpes, human papilloma virus, and syphilis.

Persons who believe they may be infected with the AIDS virus should take precautions not to infect others and to seek counseling and antibody testing to determine whether they are infected. If persons **are not** infected, counseling and testing can relieve unnecessary anxiety and reinforce the need to adopt or continue practices that reduce the risk of infection. If persons **are** infected, they should: a) take precautions to protect sexual partners from becoming infected; b) advise previous and current sexual or drug-use partners to receive counseling and testing; c) take precautions against becoming pregnant; and d) seek medical care and counseling about other medical problems that may result from a weakened immunologic system.

More detailed information about AIDS, including information about how to obtain counseling and testing for HIV, can be obtained by telephoning the AIDS National Hotline (toll free) at 800-342-2437; the Sexually Transmitted Diseases National Hotline (toll free) at 800-227-8922; or the appropriate state or local health department (the telephone number of which can be obtained by calling the local information operator).

Curriculum Time and Resources

Schools should allocate sufficient personnel time and resources to assure that policies and programs are developed and implemented with appropriate community involvement, curricula are well-planned and sequential, teachers are well-trained, and up-to-date teaching methods and materials about AIDS are available. In addition, it is crucial that sufficient classroom time be provided at *each* grade level to assure that students acquire essential knowledge appropriate for that grade level, and have time to ask questions and discuss issues raised by the information presented.

Program Assessment

The criteria recommended in the foregoing "Guidelines for Effective School Health Education To Prevent the Spread of AIDS" are summarized in the following nine assessment criteria. Local school boards and administrators can assess the extent to which their programs are consistent with these guidelines by determining the extent to which their programs meet each point shown below. Personnel in state departments of education and health also can use these criteria to monitor the extent to which schools in the state are providing effective health education about AIDS.

1. To what extent are parents, teachers, students, and appropriate community representatives involved in developing, implementing, and assessing AIDS education policies and programs?
2. To what extent is the program included as an important part of a more comprehensive school health education program?
3. To what extent is the program taught by regular classroom teachers in elementary grades and by qualified health education teachers or other similarly trained personnel in secondary grades?
4. To what extent is the program designed to help students acquire essential knowledge to prevent HIV infection at each

appropriate grade?

5. To what extent does the program describe the benefits of abstinence for young people and mutually monogamous relationships within the context of marriage for adults?
6. To what extent is the program designed to help teenage students avoid specific types of behavior that increase the risk of becoming infected with HIV?
7. To what extent is adequate training about AIDS provided for school administrators, teachers, nurses, and counselors-especially those who teach about AIDS?
8. To what extent are sufficient program development time, classroom time, and educational materials provided for education about AIDS?
9. To what extent are the processes and outcomes of AIDS education being monitored and periodically assessed?

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Appendix I

The President's Domestic Policy Council's Principles for AIDS Education

The following principles were proposed by the Domestic Policy Council and approved by the President in 1987:

Despite intensive research efforts, prevention is the only effective AIDS control strategy at present. Thus, there should be an aggressive Federal effort in AIDS education.

The scope and content of the school portion of this AIDS education effort should be locally determined and should be consistent with parental values.

The Federal role should focus on developing and conveying accurate health information on AIDS to the educators and others, not mandating a specific school curriculum on this subject, and trusting the American people to use this information in a manner appropriate to their community's needs.

Any health information developed by the Federal Government that will be used for education should encourage responsible sexual behavior-based on fidelity, commitment, and maturity, placing sexuality within the context of marriage.

Any health information provided by the Federal Government that might be used in schools should teach that children should not engage in sex and should be used with the consent and involvement of parents.

Appendix II

The Extent of AIDS and Indicators of Adolescent Risk

Since the first cases of acquired immunodeficiency syndrome (AIDS) were reported in the United States in 1981, the human immunodeficiency virus (HIV) that causes AIDS and other HIV-related diseases has precipitated an epidemic unprecedented in modern history. Although in 1985, fewer than 60% of AIDS cases in the United States were reported among persons residing outside New York City and San Francisco, by 1991 more than 80% of the cases will be reported from other localities¹.

It has been estimated that from 1 to 1.5 million persons in the United States are infected with HIV¹, and, because there is no cure, infected persons are potentially capable of infecting others indefinitely. It has been predicted that 20%-30% of individuals currently infected will develop AIDS by the end of 1991¹. Fifty percent of those diagnosed as having AIDS have not survived for more than about 1.5 years beyond diagnosis, and only about 12% have survived for more than 3 years².

By the end of 1987, about 50,000 persons in the United States had been diagnosed as having AIDS, and about 28,000 had died from the disease². Blacks and Hispanics, who make up about 12% and 6% of the U.S. population, respectively, disproportionately have contracted 25% and 14% of all reported AIDS cases³. It has been estimated that during 1991, 74,000 cases of AIDS will be diagnosed, and 54,000 persons will die from the disease. By the end of that year, the total number of deaths caused by AIDS will be about 179,000⁴. In addition, health care and supportive services for the 145,000 persons projected to be living with AIDS in that year will cost our Nation an estimated \$8-\$10 billion in 1991 alone⁴. The World Health Organization projects that by 1991, 50-100 million persons may be infected worldwide⁴. The magnitude and seriousness of this epidemic requires a systematic and concerted response from almost every institution in our society.

A vaccine to prevent transmission of the virus is not expected to be developed before the next decade, and its use would not affect the number of persons already infected by that time. A safe and effective antiviral agent to treat those infected is not expected to be available for general use within the next several years. The Centers for Disease Control⁵, the National Academy of Sciences⁶, the Surgeon General of the United States⁷, and the U.S. Department of Education⁸ have noted that in the absence of a vaccine or therapy, educating individuals about actions they can take to protect themselves from becoming infected is the most effective means available for controlling the epidemic. Because the virus is transmitted almost exclusively as a result of behavior individuals can modify (e.g., by having sexual contact with an infected person or by sharing intravenous drug paraphernalia with an infected person), educational programs designed to influence relevant types of behavior can be effective in controlling the epidemic.

A significant number of teenagers engage in behavior that increases their risk of becoming infected with HIV. The percentage of metropolitan teenage girls who had ever had sexual intercourse increased from 30%-45% between 1971 and 1982. The average age at first intercourse for females remained at approximately 16.2 years between 1971 and 1979⁹. The average proportion of never-married teenagers who have ever had intercourse increases with age from 14 through 19 years. In 1982, the percentage of never-married girls who reported having engaged in sexual intercourse was as follows: approximately 6% among 14-year-olds¹⁰, 18% among 15-year-olds, 29% among 16-year-olds, 40% among 17-year-olds, 54% among 18-year-olds, and 66% among

19-year-olds¹¹. Among never-married boys living in metropolitan areas, the percentage who reported having engaged in sexual intercourse was as follows: 24% among 14-year-olds, 35% among 15-year-olds, 45% among 16-year-olds, 56% among 17-year-olds, 66% among 18-year-olds, and 78% among 19-year-olds¹². Rates of sexual experience (e.g., percentage having had intercourse) are higher for black teenagers than for white teenagers at every age and for both sexes^{11,12}.

Male homosexual intercourse is an important risk factor for HIV infection. In one survey conducted in 1973, 5% of 13- to 15-year-old boys and 17% of 16- to 19-year-old boys reported having had at least one homosexual experience. Of those who reported having had such an experience, most (56%) indicated that the first homosexual experience had occurred when they were 11 or 12 years old. Two percent reported that they currently engaged in homosexual activity¹³.

Another indicator of high-risk behavior among teenagers is the number of cases of sexually transmitted diseases they contract. Approximately 2.5 million teenagers are affected with a sexually transmitted disease each year¹⁴.

Some teenagers also are at risk of becoming infected with HIV through illicit intravenous drug use. Findings from a national survey conducted in 1986 of nearly 130 high schools indicated that although overall illicit drug use seems to be declining slowly among high school seniors, about 1% of seniors reported having used heroin and 13% reported having used cocaine within the previous year¹⁵. The number of seniors who injected each of these drugs is not known.

Only 1% of all the persons diagnosed as having AIDS have been under age 20²; most persons in this group had been infected by transfusion or perinatal transmission. However, about 21% of all the persons diagnosed as having AIDS have been 20-29 years of age. Given the long incubation period between HIV infection and symptoms that lead to AIDS diagnosis (3 to 5 years or more), some fraction of those in the 20- to 29-year-age group diagnosed as having AIDS were probably infected while they were still teenagers.

Among military recruits screened in the period October 1985-December 1986, the HIV seroprevalence rate for persons 17-20 years of age (0.6/1,000) was about half the rate for recruits in all age groups (1.5/1,000)¹⁶. These data have led some to conclude that teenagers and young adults have an appreciable risk of infection and that the risk may be relatively constant and cumulative¹⁷.

Reducing the risk of HIV infection among teenagers is important not only for their well-being but also for the children they might produce. The birthrate for U.S. teenagers is among the highest in the developed world¹⁸; in 1984, this group accounted for more than 1 million pregnancies. During that year the rate of pregnancy among sexually active teenage girls 15-19 years of age was 233/1,000 girls¹⁹.

Although teenagers are at risk of becoming infected with and transmitting the AIDS virus as they become sexually active, studies have shown that they do not believe they are likely to become infected^{20,21}. Indeed, a random sample of 860 teenagers (ages 16-19) in Massachusetts revealed that, although 70% reported they were sexually active (having sexual intercourse or other sexual contact), only 15% of this group reported changing their sexual behavior because of concern about contracting AIDS. Only 20% of those who changed their behavior selected effective methods such as abstinence or use of condoms²⁰. Most teenagers indicated that they want more information about AIDS^{20,21}.

Most adult Americans recognize the early age at which youth need to be advised about how to protect themselves from becoming infected with HIV and recognize that the schools can play an important role in providing such education. When asked in a November 1986 nationwide poll whether children should be taught about AIDS in school, 83% of Americans agreed, 10% disagreed,

and 7% were not sure²². According to information gathered by the United States Conference of Mayors in December of 1986, 40 of the Nation's 73 largest school districts were providing education about AIDS, and 24 more were planning such education²³. Of the districts that offered AIDS education, 63% provided it in 7th grade, 60% provided it in 9th grade, and 90% provided it in 10th grade. Ninety-eight percent provided medical facts about AIDS, 78% mentioned abstinence as a means of avoiding infection, and 70% addressed the issues of avoiding high-risk sexual activities, selecting sexual partners, and using condoms. Data collected by the National Association of State Boards of Education in the summer of 1987 indicated that a) 15 states had mandated comprehensive school health education; eight had mandated AIDS education; b) 12 had legislation pending on AIDS education, and six had state board of education actions pending; c) 17 had developed curricula for AIDS education, and seven more were developing such materials; and d) 40 had developed policies on admitting students with AIDS to school²⁴.

The Nation's system of public and private schools has a strategic role to play in assuring that young people understand the nature of the epidemic they face and the specific actions they can take to protect themselves from becoming infected—especially during their adolescence and young adulthood. In 1984, 98% of 14 and 15 year-olds, 92% of 16 and 17 year-olds, and 50% of 18 and 19 year-olds were in school²⁵. In that same year, about 615,000 14- to 17-year-olds and 1.1 million 18- to 19-year-olds were not enrolled in school and had not completed high school²⁶.

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Additional copies may be requested from the National AIDS Information Clearinghouse, "Guidelines for Effective School Health Education to Prevent the Spread of AIDS" P.O. Box 6003 Rockville, Maryland 20850.

Appendix B

National Coalition of Advocates for Students

Criteria for Evaluating an AIDS Curriculum

Criteria for Evaluating an AIDS Curriculum

National Coalition of Advocates for Students

1988

National Coalition of Advocates for Students

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Criteria for Evaluating an AIDS Curriculum

Adolescents and young adults are now a primary risk group for contracting Acquired Immune Deficiency Syndrome (AIDS). At least 50% of all teenagers are sexually active; most will have more than one sexual partner, and some will be experimenting with drugs. Regardless of whether adults approve of this behavior, young people's lives may be at risk. Public schools must assume a key role in giving youth the information they need to avoid contracting this deadly disease.

Teaching about AIDS should take place within the context of a comprehensive health education or family life/sex education course. Such a course should present the positive aspects of sexuality as well as its dangers. An AIDS curriculum must be appropriate to the chronological and developmental age of the student as suggested in Attachment A, and should be taught in small groups of 20 or fewer students.

Below is a checklist for parents, child advocates, school board members, teachers and administrators to evaluate existing AIDS curricula and to advocate for the establishment of high quality curricula. An effective AIDS curriculum should elicit "yes" answers to the following questions:

Curriculum Content

	Yes	No
For students in grades 6 and up, does the curriculum give simple, clear and direct information about AIDS transmission and prevention? (See Attachment B)	☐	☐
Does the curriculum help students acquire the necessary self-esteem and assertiveness to choose to abstain from sexual intercourse?	☐	☐
Does the curriculum inform all students about effective ways to prevent infection when they become sexually active including information about condoms and their correct use?	☐	☐
Does the curriculum focus on teaching students how to make healthy sexual decisions and not just on the medical aspects of AIDS?	☐	☐

Contents

Criteria for Evaluating an AIDS Curriculum (Checklist)

Attachment A: Matching Approaches to AIDS Education with Childhood Development

Attachment B: What Adolescents Should Know About AIDS

Attachment C: Staff Training

Attachment D: Parental and Community Involvement

	Yes	No
By emphasizing high-risk behaviors rather than high-risk groups, does the curriculum strongly convey the message that ANYONE can get AIDS regardless of race, sex, age or sexual orientation?	☐	☐
Does the curriculum affirm that people have natural sexual feelings?	☐	☐
Are several class periods provided to give each student multiple opportunities to rehearse making decisions based on the information they have learned about AIDS?	☐	☐
Does the curriculum allay young children's fears of AIDS?	☐	☐
Does the curriculum give young children a foundation for more detailed discussion of sexuality and health at the 6th grade level and later?	☐	☐

Development and Implementation

	Yes	No
Does the program provide for adequate staff training to teach the curriculum? (See Attachment C)	☐	☐
Are staff helped to examine their own attitudes about sexuality and AIDS?	☐	☐
Are staff given accurate and detailed information about AIDS?	☐	☐
Are staff trained in the concrete skills needed to teach effectively an AIDS curriculum?	☐	☐
Is the same information given to limited English proficient students in their own language?	☐	☐
Is the information provided appropriately to students with hearing and visual impairments and to students with severely disabling conditions?	☐	☐
Is the curriculum updated regularly to incorporate new information as it becomes available?	☐	☐
Has sufficient community and parental support been generated to give teachers the backing they need to teach sensitive material in a direct manner?	☐	☐
Does the curriculum facilitate an on-going dialogue with parents on these issues? (See Attachment D)	☐	☐

Attachment A

Matching Approaches to AIDS Education with Childhood Development

Students in a particular grade may vary widely in their emotional development. Teachers are urged to individualize their teaching where appropriate, while keeping in mind that the following statements are apt to characterize the vast majority of their students.

Developmental Characteristics of Students

Grades K through 3

Students are likely to be:

- egocentric;
- developing some independence from parents and gradually orienting toward peers;
- able to relate to their own bodies/be curious about body parts;
- highly competitive and capable of unkindness to each other;
- able to understand information if it relates to their own experiences.

Appropriate Approaches to AIDS Education

Grades K through 3

The primary goal is to allay children's fears of AIDS and to establish a foundation for more detailed discussion of sexuality and health at the 6th grade level.

- Information about AIDS should be included in the larger curriculum on body appreciation, wellness, sickness, friendships, assertiveness, family roles and different types of families.
- Children should be encouraged to feel positively about their bodies and to know their body parts and the difference between girls and boys. Teachers should answer their questions about how babies are developed and born.
- AIDS should be defined simply as a very serious disease that some adults and teenagers get. Students should be told that young children rarely get it and that they do not need to worry about playing with children whose parents have AIDS or with those few children who do have the disease.
- Children should be cautioned never to play with hypodermic syringes found on playgrounds or elsewhere and to avoid contact with other people's blood.
- Questions should be answered directly and simply; responses should be limited to questions asked.
- Children should be taught assertiveness about refusing unwanted touch by others, including family members.

Developmental Characteristics of Students

Grades 4 and 5

Students are likely to be:

- aware of sexual feelings and desires either in themselves or in others and confused about them;
- increasingly sensitive to peer pressure;
- capable of concern for others;
- exploring sex roles;
- in different stages of prepuberty and early puberty and usually very interested in learning about sexuality and human relationships;
- quite comfortable discussing human sexuality;
- confused between fact and fancy (between hypothesis and reality);
- able to internalize rules and know what is right or wrong according to those rules.

Appropriate Approaches to AIDS Education

Grades 4 and 5

It is appropriate to use the same approach as for grades K-3 with an increased emphasis on:

- affirming that bodies have natural sexual feelings;

- helping children examine and affirm their own and their families' values. Teachers of 4th and 5th graders should:
- continue providing basic information about human sexuality, helping children understand puberty and the changes in their bodies;
- be prepared to answer questions about AIDS and AIDS prevention.

Developmental Characteristics of Students

Grades 6 through 9

Students are likely to be:

- engaged in a search for identity (including sexual identity); asking "Who am I?" and "Am I normal?;" very centered on self;
- influenced by peer attitudes;
- concerned about and experimenting with relationships between boys and girls;
- confused about the homosexual feelings many of them will have experienced;
- worried about the changes in their bodies;
- able to understand that behavior has consequences, but may not believe the consequences could happen to them;
- fearful of asking questions about sex which might make them appear uninformed.

Grades 10 through 12

Students are likely to be:

- still struggling for a sense of personal identity, especially those who are confused about their sexual identities;
- thinking that they "know it all;"
- seeking greater independence from parents;
- open to information provided by trusted adults;
- near end of this period, beginning to think about establishing more permanent relationships;
- experiencing an illusion of immortality;
- sexually active.

Appropriate Approaches to AIDS Education

Grades 6 through 12

The primary goal is to teach students to protect themselves and others from infection with the AIDS virus.

- Students should learn all of the information on Attachment B—"What Adolescents Should Know About AIDS."
- AIDS issues should be made as real as possible without overly frightening students. Movies about or classroom visits from people with AIDS have helped students in some schools overcome their denial of the disease and give AIDS a human face.
- The focus should be on healthy behaviors rather than on the medical aspects of the disease.
- Students should examine and affirm their own values.
- Students should rehearse making responsible decisions about sex, including responses to risky situations.
- Students should know they have a right to abstain from sexual intercourse or to postpone becoming sexually active. They should be helped to develop the skills to assert this right.
- It must not be assumed that all students will choose abstinence.
- Information about AIDS should be presented in the context of other sexually transmitted diseases (STDs).
- It is important to be honest and to provide information in a straightforward manner. Be explicit. Use simple, clear words. Explain in detail. Use examples.
- Sexual vocabulary should be connected with slang if necessary, to be certain students understand the lesson.
- It is important to be non-threatening and to work to alleviate anxiety.
- Students should be given the opportunity to ask questions anonymously.
- Discussion of dating relationships can provide opportunities to teach decision-making skills. Students should be helped to think

through how to make responsible decisions about sex before questions arise in a dating context.

- Teaching about AIDS is often enhanced by:
 - movies and other visual aids;
 - role plays and other participatory exercises;
 - same-sex groupings (to encourage more candid discussion) followed by sharing in a mixed-sex group (to increase comfort level in discussing sexual subjects with members of the opposite sex);
 - involvement of students in planning and teaching—let young people speak the message to each other whenever possible.
- AIDS education should also include discussion of critical social issues raised by the epidemic, such as protecting the public health without endangering individual liberties.
- Teachers should have resources to help students find answers to detailed medical questions.
- Students should be taught skills that will enable them to continue to evaluate the AIDS crisis.

Attachment B

What Adolescents Should Know About AIDS

The information adolescents need is simple and straightforward. Home and school instruction should emphasize prevention through teaching safe behaviors. While adolescents need only minimal knowledge of the medical aspects of the disease, some may seek a more in-depth understanding of the virus and its manifestations. Teachers and parents should be prepared to answer their questions.

This is what should be appropriately communicated to all adolescents:

Definition of AIDS

A disease triggered by infection with the human immunodeficiency virus (HIV) which weakens the immune system causing the infected person to catch certain diseases that healthy people can fight off, but that can be fatal to a person with AIDS. Unlike most infections, HIV infection does not go away. The virus remains in the person's body for the rest of her or his life.

Transmission of HIV

HIV is extremely difficult to catch. It is not transmitted by casual contact such as hugging, sneezing, or sharing bathrooms.

There is no danger of getting AIDS by donating blood. A few years ago, some people became infected with HIV through receiving blood transfusions. Now, however, all blood donations are screened and tested so that the blood supply is quite safe.

HIV is transmitted in three main ways:

1. through infected semen and vaginal secretions (by vaginal or anal sexual intercourse or, possibly, by oral sex);
2. through infected blood (by sharing intravenous IV drug needles or using unsterile hypodermic needles for steroids or any other purpose);
3. from an infected mother to her child either before or during childbirth and, possibly, through breast milk.

Anyone who engages in risky behaviors can become infected, regardless of gender, sexual orientation, age or race.

Three Manifestations of Infection

1. Many people who are infected with the virus have no symptoms of disease. Since they look and feel healthy, these people may not know they are infected. They can, however, transmit HIV to others through unprotected sexual intercourse, sharing unsterile needles or childbirth. Many, if not all, of these carriers will eventually become symptomatic. Most of them, however, will not become sick for three to seven years or more after infection.
2. Persons who are infected with HIV may develop symptoms which are related to AIDS, but have not reached the clinical definition of AIDS. This is sometimes called AIDS Related

Complex (ARC). They may be only mildly ill or very sick.

3. Manifestations of AIDS can include opportunistic infections and cancers as well as neurological and psychological problems.

Testing

It is now possible to test blood, in most cases, to determine if a person is a carrier of HIV. At this time, the Centers for Disease Control and the U.S. Surgeon General do not recommend testing of the general population. However, men and women who are considering parenting and who practice risky behaviors are advised to be tested. Anyone thinking of being tested should contact an alternative test site which tests anonymously and offers pre- and post-test counseling. State and local public health departments can give addresses of local testing facilities.

Adolescents Can Prevent AIDS By:

- abstaining from or postponing becoming sexually active;
- only having sexual relations within the context of a mutually faithful relationship with an uninfected partner;
- always using latex condoms (even in combination with other birth control) from beginning to end of all types of intercourse, preferably with a spermicidal jelly containing nonoxonyl 9;
- not using intravenous drugs. Those who do should never share needles or syringes and should be encouraged to enter a drug treatment program. Those who continue to share needles should be told how to sterilize their equipment. Tattoo needles and needles used for injecting body-building hormones or for piercing ears should also never be shared.

Local Telephone Number

Students should be given a local telephone number to call for additional information. Sources of AIDS information in other languages should also be provided. Some local AIDS hotlines have Spanish-speaking staff available during certain hours. Find out what these hours are and provide this information to Spanish-speaking students. Health clinics and other community organizations serving the Latino, Chinese and other language minority communities may also be able to provide AIDS counseling in those languages.

National AIDS Hotline

1-800-342-2437

AIDS information in English & Spanish 24 hours a day

Attachment C

Staff Training

Staff training is a must. Two types should be provided:

I. Staff In-Service

All staff (teachers, administrators, custodians and clerical personnel) should receive basic information about AIDS. They should understand its transmission and prevention and know where to turn in the school and in the community for more information and help.

Someone in each school should be designated as an AIDS resource person. Each school district should have a similar AIDS resource staff person at the central office level.

AIDS education at this level can be conducted as a one or two session in-service workshop. Public health departments and local AIDS service agencies can usually provide knowledgeable workshop leaders.

II. Preparation For Teaching AIDS Prevention

Training teachers to teach AIDS prevention is much more rigorous than staff in-service. All teachers and supervisory administrators who will be teaching AIDS prevention education must receive this more comprehensive training. When feasible, participants should be offered graduate level credit.

There are three components to effective training to teach AIDS prevention:

1. **Context**-Before staff are trained to teach a curriculum, a supportive context for the program must be developed within the community. A community public education campaign may be needed to help parents and other members of the community understand the importance of AIDS prevention education. This is necessary if teachers are to be free to discuss with students the many sensitive issues raised by the AIDS epidemic. See Attachment C on Parental and Community Involvement.
2. **Content**-Training should include:
 - accurate and detailed information about AIDS and a chance for participants to process this information in a way that alleviates their own fears of exposure to the virus;
 - an examination of the sensitive and controversial issues involved in AIDS prevention; staff should be helped to look at their own attitudes about sexuality and AIDS;
 - classroom strategies and activities, including models for integrating AIDS education into comprehensive units on health and family life education.
3. **Methodology**-Teachers should be trained to impart information to students in a way which personalizes the issues and helps students realize that AIDS affects them. Training should enable teachers to identify (a) specific student behaviors which they want to change and (b) skills students need to affect those behavioral changes. These skills concern decision-making, effective communication, and assertiveness. Teachers should be further trained to provide a context where students can practice using these skills. A good training program will give teachers practice in building the skills they in turn will teach their students.

Teachers who are uncomfortable with the subject matter should not be required to teach an AIDS unit. Their confusion and discomfort will inevitably be conveyed to their students.

Teachers who do agree to teach AIDS units should be offered opportunities to team teach or to draw on outside resource people for support and assistance.

Family planning agencies can help identify sexuality educators to lead this training. Effective training may also involve significant participation of parents and students.

(This attachment has been excerpted from training strategies developed by ETR Associates, Santa Cruz, CA)

Attachment D

Parental and Community Involvement

It is important to include parents and community leaders in the development and implementation of AIDS curricula. By doing so, you will:

- educate key community members about AIDS and the risks it poses to adolescents;
- involve parents in an important way in their children's education;
- develop a curriculum which considers the ethnic and cultural roots of sexual attitudes;
- build respect and a broad validation for the curriculum;
- build a solid base of supportive community members who can speak to opposition which may arise;
- give teachers the support they need to teach sensitive material in a direct manner.

Two effective means of facilitating parent/community participation are:

I. An AIDS Education Advisory Committee

Form an Advisory Committee to work with key school personnel: to design a program; to provide information to the community; and to present the program to the local school board. The committee might include parents, religious leaders, student leaders, elected officials, and staff of community agencies. Be sure the committee reflects the true racial and ethnic diversity of the community. While it is important that all members concur on the importance of effective AIDS education, committee members should reflect a broad range of community perspectives.

While the primary mandate of the Advisory Committee is the timely implementation of an AIDS curriculum, it should also begin to lay the groundwork for a comprehensive health and sexuality education program. It is through such a comprehensive program that students can acquire the self-esteem and decision-making skills necessary to make healthy choices about AIDS and other important life issues.

II. Parental Component of the AIDS Curriculum

At the same time students are taught about AIDS, parents should also be educated about the disease, its transmission and prevention. A well-planned and publicized parent information night is one method. A second effective strategy is a parent/student communication component built into the curriculum itself. Students are then empowered to be educators themselves, perhaps assisted by a study guide to use in teaching their parents. The benefits of this approach include:

- reinforcement of classroom learning;
- education of parents about AIDS;
- facilitation of a dialogue between students and parents about sexuality issues.



Appendix C

Library Resources

Books for Youth

Non-fiction For Older Readers

Blake, Jeanne. *Risky Times: How to be AIDS-Smart and Stay Healthy*. New York, Workman Publishing, 1990.

This book speaks directly to teenagers. Six high school students from Cambridge, Massachusetts offer their opinions on everything from sex to drugs to condom use. Teens' heroes and role models like Susan Dey, Bo Jackson, Whoopi Goldberg and Brooke Shields offer advice and stress compassion for those infected with HIV. Jeanne Blake, a Boston-based television medical reporter, is the author. Her writing is intelligent, sensitive, and filled with respect for her young readers.

Colman, Warren. *Understanding and Preventing AIDS*. Chicago, Children's Press, 1987.

A full treatment of the history, current knowledge, prevention and future of HIV, including a chapter called "Cures, Controls and Vaccine." Includes color and black-and-white photographs and addresses of state and national AIDS information organizations.

Hawkes, Nigel. *AIDS: Issues...Issues...Issues*. New York, Gloucester Press, 1987.

Especially suitable for browsing, a 32-page, large-format book with large illustrations, and color and black-and-white photographs. Includes short, concise sections.

Hein, Karen and DiGeronimo, Theresa Foy. *AIDS: Trading Fears for Facts*. Mount Vernon, N.Y., Consumers Union, 1989.

This book offers a straightforward, unbiased resource teenagers can turn to for the information they need. Addresses teen questions, concerns, and misconceptions about AIDS. The book is coauthored by Karen Hein, M.D., director of the nation's first adolescent AIDS program and Theresa Foy DiGeronimo, an experienced writer of young-adult materials.

Hyde, Margaret O., and Forsyth, Elizabeth H. *AIDS: What Does It Mean to You?* New York, Walker, 1987.

An updated, informative and highly readable account of AIDS and its vast cultural implications. Revised and expanded from the 1986 original. Includes information on ARC and AZT, a glossary, charts, diagrams, and addresses and phone numbers of national organizations.

Levert, Suzanne. *AIDS: In Search of a Killer*. New York, Simon & Schuster, 1987.

An overview of the history of HIV, including helpful chapters on AIDS and civil rights, and health care and human dignity. Includes case studies, information on ARC and AZT, a glossary, and AIDS information resources.

Marsh, Carole S. *Sex Stuff: A Book of Practical Information and Ideas for Kids 7-17, and Their Teachers and Parents*. Bath, N.C., Gallopade Publishing Group, 1987.

Includes a section on AIDS.

Nourse, Alan E. *AIDS*. New York, Watts, 1986.

A straightforward scientific account of HIV, from discovery to

1986. Includes several black-and-white cell photos, statistical tables and a glossary.

Saint Phalle, Niki de. *AIDS: You Can't Catch It Holding Hands*. San Francisco, Lapis Press, 1987.

A picture book for young adults featuring surreal illustrations and a hand-written text. Information is conveyed through a letter written by a mother to her son, giving the topic a personal quality.

Silverstein, Alvin and Virginia. *AIDS: Deadly Threat*. Hillside, N.J., Enslow, 1986.

A detailed analysis of the virus, its detection, facts and myths regarding HIV, and a chapter called "The World Reacts." Includes suggested reading list, black-and-white photographs, drawings, charts and glossary.

Wachter, Oralee, and Kesden, Brad. *Sex, Drugs & AIDS*. Toronto, Bantam Books, 1987.

A straightforward account of the impact of HIV on today's teenagers. Transcribed from a popular film, the text spoken by narrator Rae Dawn Chong addresses such issues as facts and myths about contracting HIV and preventing HIV infection. Includes black-and-white photos, large type, and a listing of AIDS resources and telephone hotlines.

For Younger Readers

Hyde, Margaret O., and Forsyth, Elizabeth H. *Know About AIDS*. New York, Walker, 1987.

An excellent account of HIV and its effect on society, especially as felt by younger children. A simple presentation that includes black-and-white illustrations and suggestions for further reading.

Lerner, Ethan A. *Understanding AIDS*. Minneapolis, Lerner Publications, 1987.

An introduction to AIDS touching on, but not fully explaining some major issues regarding the disease. Useful as a basis for discussion.

Schilling, Sharon and Swain, Jonathan. *"My Name is Jonathan (and I Have AIDS)"*. Denver, Colo., Prickly Pair Publishing & Consulting Company, 1989.

This book was written for students in grades K-6, to help them and their parents understand why it is safe for a child with AIDS to go to school. The purposes of the book are: to establish that casual contact, even that of a personal nature in a home environment, does not provide a means of transmitting HIV; to help children and their parents understand better how a child's life is affected by having AIDS; and to emphasize that, while concessions must be made for the disease, a child with AIDS is first and foremost a child, with fears, hopes and dreams just like those of other children.

Fiction

Kerr, M.E. *Night Kites*. New York, Harper & Rowe, 1986.

Erick Rudd's brother Peter has AIDS, one of several major problems Erick faces during his senior year. Erick's relationships with former girlfriend Dill, former best friend Jack, new girlfriend Nicki, and his family compete for his attention.

Miklowitz, Gloria D. *Good-Bye Tomorrow*. New York, Delacorte, 1987.

High school athlete Alex learns he has been infected with HIV through a blood transfusion. Alex fears he has infected his girlfriend Shannon, loses his job at the local pizza parlor and faces hostility from fellow athletes on the swim team. School administrators and students react with fear and ignorance, depicting real-life struggles faced by adolescents with AIDS.

Books for Adults Working with Youth

Centers for Disease Control. *Adolescent and School Health Resources: HIV and AIDS. A Cumulation of the AIDS School Health Education Database*. Atlanta, Georgia, Centers for Disease Control, April, 1990.

This publication contains the citations and abstracts of the more than 600 resources entered into the AIDS School Health Education Database through April 1990. These citations and abstracts describe educational materials and other relevant information resources on HIV infection and AIDS for educators to use in teaching children, youth, and college-aged students about HIV infection and AIDS. These materials include audiovisuals, books/book chapters, bibliographies, directories, brochures/pamphlets, journal articles, policies and guidelines, papers, statements, programs, reports, teaching guides and curricula, computer assisted instruction, sound recordings, instructional packages, posters, scripts, and comic books. For more information write to the following address: Centers for Disease Control, Center for Chronic Disease Prevention & Health Promotion, Division of Adolescent and School Health Mailstop K31, Attention: AIDS School Health Education Database, Atlanta, Georgia 30333.

Jacobs, George, and Kerrins, Joseph. *The AIDS File: What We Need to Know About AIDS Now!* Woods Hole, Mass., Cromlech, 1987.

This book designed for adults has succinct and highly useful information such as why, when, what and how parents should tell their children about AIDS.

Madaras, Lynda. *Lynda Madaras Talks to Teens About AIDS*. New York, Newmarket Press, 1988.

The author explains the facts about HIV to youth ages 14-19, covering how the virus is and is not transmitted, who gets it, and symptoms. She also gives comprehensive information regarding abstinence, risk reduction behaviors, proper condom use, and talking to potential partners. Includes a preface for teachers and other adults.

Quackenbush, Marcia, Nelson, Mary, and Clark, Kay eds. *The AIDS Challenge: Prevention Education for Young People*. Santa Cruz, Calif., Network Publications, 1988.

This book brings together resources for designing, implementing, and evaluating successful AIDS prevention education programs—in schools and out—for youth of all ages. The nation's foremost experts on AIDS and education contributed chapters to this compendium which covers: approaches for delivering age-appropriate prevention information; ways to reach minority youth and special populations; perspectives on the religious, legal and medical issues involved in AIDS education; and other key concerns.

Quackenbush, Marcia, and Sargent, Pamela. *Teaching AIDS: A Resource Guide on Acquired Immune Deficiency Syndrome*. (3rd edition) Santa Cruz, Calif., Network Publications, 1990.

This book can be used to educate both teens and adults about HIV/AIDS. The guide includes updated information on the symptoms, transmission, testing, and treatment of HIV/AIDS, as well as teaching plans and activities. This book also provides updated figures and projections, a discussion about the changing high-risk behavior of teens, and specifics on the evolving language of the epidemic.

Quackenbush, Marcia, and Villareal, Sylvia. *Does AIDS Hurt? Educating Young Children about AIDS*. Santa Cruz, Calif., Network Publications, 1988.

This publication speaks directly to issues involved in educating children (preschool to age 10) about AIDS. Gives parents, teachers, and others who care for children suggestions and guidelines for talking with them about AIDS.

Shilts, Randy. *And the Band Played On: Politics, People and the AIDS Epidemic*. New York, Viking/Penguin Inc, 1988.

This investigative reporter's account of the HIV epidemic in the early '80s was a national best-seller. The 1988 edition explores important HIV policy decisions since 1987. Essential reading for all concerned with the HIV epidemic.

Yarber, William L. *AIDS Education: Curriculum and Health Policy*. Bloomington, Ind., Phi Delta Kappa, 1988.

This fastback is designed to help schools develop an AIDS education curriculum focusing on preventive behaviors. It also provides policy guidelines for dealing with persons with AIDS in the school. Special features include an AIDS knowledge self-test and a comprehensive list of AIDS education resources.

Many of the resources listed in this appendix were cited with permission from the American Library Association from their pamphlet, AIDS: Acquired Immune Deficiency Syndrome.



Appendix D

Example of a Student Self-Instructional Packet for HIV Prevention

1. Assess your knowledge of the subject by completing the pretest, which is on the next page.
2. Watch the video *Don't Forget Sherrie* (produced by the American Red Cross).
3. Complete the Reaction to the Video Sections I and II.
4. Assess the changes in your knowledge and attitudes by completing the posttest on the next page.
5. Turn in this packet in order to obtain credit.

The activities and tests in this section were reprinted and adapted with permission from *Educational Activities to Assist with the Implementation of AIDS Concepts in the Classroom*, by Norma Ann Farone, MEd, and Carol Ann Dimarco Cummings, PhD, February 1988.

PRETEST

PURPOSE: To assess pretest and posttest knowledge levels.

DIRECTIONS: Decide if the statement is true or false. Check the appropriate box.

- | | True | False |
|---|--------------------------|--------------------------|
| 1. AIDS is caused by a bacteria. | ☐ | ☐ |
| 2. Heterosexuals cannot contract HIV. | ☐ | ☐ |
| 3. Having unprotected sex can spread HIV. | ☐ | ☐ |
| 4. Sharing injected drug needles can spread HIV. | ☐ | ☐ |
| 5. There is a cure for AIDS. | ☐ | ☐ |
| 6. There is a test for the antibody of the AIDS virus. | ☐ | ☐ |
| 7. HIV cannot be spread by casual contact. | ☐ | ☐ |
| 8. Some people may be infected with HIV but do not appear to be sick. | ☐ | ☐ |
| 9. The spread of HIV can be controlled by avoiding high-risk behavior(s). | ☐ | ☐ |
| 10. HIV causes the immune system to become deficient. | ☐ | ☐ |

PRETEST AND POSTTEST ANSWER KEY

- | | |
|-------|------|
| J '01 | J '5 |
| J '6 | J '4 |
| J '8 | J '3 |
| J '2 | J '2 |
| J '9 | J '1 |

Reaction to the Video *Don't Forget Sherrie*

1. Assess your understanding of HIV/AIDS concepts by completing the following quiz.

Directions: Check the box next to the most correct answer.

1. The current name for the virus which causes AIDS is:
 - ☐ a. HIV
 - ☐ b. HTLV-III
 - ☐ c. LAV
 - ☐ d. ARV
 - ☐ e. None of the above

2. A high risk behavior to avoid because it can transmit HIV is
 - ☐ a. Casual contact
 - ☐ b. Hugging someone with AIDS
 - ☐ c. Having unprotected sex
 - ☐ d. Kissing
 - ☐ e. none of the above
3. HIV cannot be transmitted by
 - ☐ a. Sharing needles
 - ☐ b. Unprotected sex
 - ☐ c. A woman with AIDS who gives birth
 - ☐ d. Abstinence
4. The cure for AIDS is
 - ☐ a. A vaccine
 - ☐ b. An antibiotic
 - ☐ c. Early detection of the disease
 - ☐ d. There is no known cure
5. Which situations put one at risk for acquiring HIV?
 - ☐ a. Infants born to a mother infected with HIV
 - ☐ b. Teens who have had unprotected sex
 - ☐ c. Adults who have shared injected drug needles
 - ☐ d. Teens who share needles to inject steroids
 - ☐ e. All of the above
6. What is the best method to stop the spread of HIV?
 - ☐ a. Abstinence from sexual activity
 - ☐ b. Abstinence from injected drug usage
 - ☐ c. Using a latex condom only
 - ☐ d. Using a diaphragm and spermicide
 - ☐ e. a & b
7. If a person is planning to engage in sexual activity, the best method of HIV prevention is
 - ☐ a. Using a latex condom only
 - ☐ b. Using a latex condom with a spermicide
 - ☐ c. Using a spermicide only
 - ☐ d. Using a diaphragm
 - ☐ e. None of the above
8. HIV has been found in which of these body fluids?
 - ☐ a. Blood
 - ☐ b. Semen
 - ☐ c. Vaginal secretions
 - ☐ d. Saliva
 - ☐ e. All of the above
9. Which of the following body fluids can transmit HIV?
 - ☐ a. Blood
 - ☐ b. Semen
 - ☐ c. Vaginal secretions
 - ☐ d. Breast milk
 - ☐ e. All of the above



10. Which of the following racial/ethnic groups in the United States has the greatest number of AIDS cases?

- ☐ a. Blacks
- ☐ b. Hispanics
- ☐ c. Asians
- ☐ d. Native Americans

ANSWER KEY FOR QUIZ

- a 101 c 5
e 6 d 4
e 8 d 3
b 7 c 2
e 9 a 1

II. Tim (T.J.) and Robin, the major characters in the video, had a number of decisions to make in regard to protecting their health. Health-enhancing behavior is facilitated by using a decision-making model. The components of a decision-making model include:

- Identifying the decision to be made.
- Identifying the various alternatives to the situation.
- Listing the positive and negative consequences of each alternative.
- Ranking each alternative.
- Deciding if more information is needed.
- Making a choice.
- Evaluating that choice:
Would implementing this choice be health enhancing? safe?
harmless to self and others? legal?

Using some of the statements made in the video as well as your own beliefs, help the characters in the following scenarios make some decisions regarding their sexual health.

Scenario 1

Bob and Cassie are a couple who have been dating for one year and have discussed the possibility of having a sexual relationship. They are both very much in love and are hoping to get married in the future. Cassie insists that Bob wear a condom if they have sexual intercourse but he absolutely refuses. He wants her to use the birth control pill. She is concerned about infection with HIV and STDs.

1. What decision must Bob and Cassie make?

2. What are the available alternatives?

a) _____

b) _____

c) _____

d) _____

e) _____

4. What further information is needed to make a decision?

5. Rank order the various alternatives:

Best alternative _____

Worst alternative _____

6. Which alternative should Bob and Cassie choose?

Scenario 2

David and Laura are two recovering intravenous drug abusers. They have decided to get married. David has been clean for one year. Laura wants both of them to have an HIV antibody test done. David does not feel that he needs to have a test done and has refused.

1. What decision must Laura make?

2. What are the available alternatives?

a) _____

b) _____

c) _____

d) _____

e) _____

4. What further information is needed to make a decision?

5. Rank order the various alternatives:

Best alternative _____

Worst alternative _____

6. What decision should Laura make?

POSTTEST

PURPOSE: To assess pretest and posttest knowledge levels.

DIRECTIONS: Decide if the statement is true or false. Check the appropriate box.

	True	False
1. AIDS is caused by a bacteria.	☐	☐
2. Heterosexuals cannot contract HIV.	☐	☐
3. Having unprotected sex can spread HIV.	☐	☐
4. Sharing intravenous drug needles can spread HIV.	☐	☐
5. There is a cure for AIDS.	☐	☐
6. There is a test for the antibody of the AIDS virus.	☐	☐
7. HIV cannot be spread by casual contact.	☐	☐
8. Some people may be infected with HIV but do not appear to be sick.	☐	☐
9. The spread of HIV can be controlled by avoiding high-risk behavior(s).	☐	☐
10. HIV causes the immune system to become deficient.	☐	☐

(Answers for this posttest are on the preceding page)



Appendix E

American School Health Association

AIDS/HIV Position Statements

School Attendance of HIV Infected Students and Employment of School Personnel with HIV Infection: Most HIV-infected students and children should be admitted freely to all activities to the extent that their health permits. Medical evaluation should be ongoing to evaluate changes in the child's health. The decision as to whether a child with HIV infection must attend an alternative placement should be made on a case-by-case basis. Screening of children entering school programs for the presence of HIV antibody is not warranted or recommended.

HIV-infected school personnel do not present a health hazard to students or co-workers as a result of this infection or their occupational activities. Criteria for alteration in their employment status for health reasons should be the same as for other personnel. Routine HIV antibody screening of school personnel is not indicated and there should be no obligation on the part of the individual to inform the school administration of his/her HIV status.

Confidentiality of HIV Status of Students in Schools: The risks of a breach in confidentiality concerning a student's HIV infection status prohibit routine disclosure of that status to school personnel. Information regarding a child who has HIV, whatever its etiology, should be available to those caretakers who need to know. In many cases, this would include only the child's physician and parents or guardians. If school personnel are to be told of the HIV status of a student, the number of personnel informed must be kept to a minimum and might include the superintendent, principal, school nurse, and teacher.

School-based HIV Education: The ASHA supports the implementation of school HIV education programs through sequential K-12 comprehensive school health programs.

All position statements were adopted by the ASHA Executive Committee, October 1, 1988.

Appendix F

Sample School District AIDS/HIV Policies from National School Boards Association (NSBA) Clearinghouse

Sample AIDS/HIV Policies from Broken Arrow Public Schools, Broken Arrow, Oklahoma

2-47 Aids Prevention Education Instructional Program

- 2-47-1 Intent of the instructional program on Acquired Immune Deficiency Syndrome (AIDS) is to provide information about the disease, methods of transmission and prevention appropriate to specified grade levels.
- 2-47-2 AIDS instruction will begin in Grade 5 and continue through Grade 12.
- 2-47-3 During the 1987-88 school year, instructional activities for Grades 5-12 will be conducted. Thereafter, appropriate curriculum will be taught in Grades 5, 6, 8 and 10.
- 2-47-4 Instruction for students in Grade 5 will be limited to the origin, history and definition of AIDS. Excluded from instruction at this grade level will be methods of transmission and prevention.
- 2-47-5 Instruction for students in Grades 6 and above will include the origin, history and definition of AIDS, and the methods of transmission and prevention.
- 2-47-6 Specific instructional activities shall be maintained in the instructional guide for AIDS education, to be monitored by the Assistant Superintendent for Instructional Services, who, through recommendation of revisions in the program to the Board of Education, shall update and modify the curriculum as new information about AIDS is made public. Any curriculum and materials developed for use in the AIDS Prevention Education Instructional Program shall be approved for medical accuracy by the State Department of Health.
- 2-47-7 During periods of AIDS instruction, students will be separated by sex and placed in smallest groups possible, dependent upon student membership of the particular grade and school.
- 2-47-8 The building principal shall assign the school nurse and/or other qualified personnel to teach AIDS prevention education.
- 2-47-9 Adequate training from health department personnel and/or private medical sources, shall be provided all nurses and teachers who are assigned to teach AIDS prevention education.
- 2-47-10 Prior to the start of the student instructional program and at any time thereafter parents and guardians of students who will be involved with the curriculum and materials shall have an opportunity to preview the curriculum and materials in a specific program being presented. Thereafter, any parent or guardian may review the curriculum and materials at any time including any

revisions in the program to update and modify the curriculum as new information about AIDS is made public. The School District, at least one (1) month prior to teaching AIDS prevention education in any classroom, shall conduct for the parents and guardians of the students involved, during weekend and evening hours, at least one (1) presentation concerning the curriculum and materials that will be used for such education. Parents and guardians will be given the opportunity to have their student(s) exempt from participation in the AIDS instruction program.

- 2-47-11 On an annual basis, all employees of the school district will view an appropriate training film which addresses all learner outcomes of the AIDS prevention education program. A school nurse shall present the film and be available for questions following viewing of the film.

Source: Broken Arrow Board of Education policy adoption, November 16, 1987.

Sample AIDS/HIV Policies from Federal Way School District, Federal Way, Washington

Communicable Disease

P 5139

It is the responsibility of each school district to meet Washington State requirements and regulations with regard to the control of communicable diseases. Therefore, the Federal Way School District shall develop regulations and procedures necessary for the control of communicable disease in the schools. All procedures will conform with the regulations for communicable disease control established by the Washington State Department of Social and Health Services, Division of Health.

Legal Reference:

RCW 28A.31.100 through 120—Washington State
Immunization Law
WAC 180-38-005 through 070—Pupils Immunization
Requirements
WAC 248-100-163—Immunization of School Children
WAC 248-101—Communicable Disease

Adopted: 10-22-79 as Student Immunization
Amended: 3-23-87 as Communicable Disease

COMMUNICABLE DISEASE

R 5139

These regulations are designed to provide effective precautions against transmission of disease in the school setting. They apply to students and staff and address immunization, exposure to blood and other body fluids, viral and bacterial diseases, sanitation and exclusion procedures. A communicable disease shall be any illness or condition which is defined as such by the State in WAC 248-101-020.



A. District Health Advisory Committee

1. The District Health Advisory Committee is established for the purpose of reviewing and recommending curriculum related to health and chemical substance abuse.
2. The Health Advisory Committee includes: Coordinating Teacher for Health; Coordinating Teacher for Drug and Alcohol; Director of Curriculum, 1 elementary principal; 1 secondary principal; 1 school nurse; school physician; 1 school guidance counselor; 1 minister; 1 patron from each junior high service area; 1 junior high student; 1 senior high student; 1 elementary teacher; 1 junior high teacher; 1 senior high teacher.
3. Topics to be addressed by the District Health Advisory Committee include:
 - Communicable Disease Prevention Curriculum
 - Hygiene Practices

B. Education of Students and Staff

1. The District shall provide education for students and staff regarding communicable diseases and appropriate preventive procedures. This education shall occur through normal health curriculum units, classroom instruction, and specific inservice training. The educational programs shall have been approved by the District Health Advisory Committee.
2. Students shall receive specific instruction on safety and sanitation procedures for any classroom activities involving use of body fluids, e.g.: blood typing and saliva culturing. The Curriculum Director shall instruct the appropriate coordinating teacher to select a committee of staff members to define the specific procedures. The Coordinator of Health Services shall participate on the committee and review the proposed procedures with regard to control of communicable disease. These procedures shall be printed and used throughout the District whenever the activity occurs.

C. Student Immunization

1. The District will follow the guidelines established by the Washington State Department of Social and Health Services, Office of Disease Prevention and Control, regarding immunization of students and exclusions.
2. At the time of initial enrollment a Certificate of Immunization Status, distributed by the Washington Department of Social and Health Services (DSHS), shall be completed by the student's parent/guardian. The certificate shall be made a part of the student's health record.
3. Exemptions from one or more vaccines shall be granted for medical reasons upon certification by a physician that there is medical reason for not administering the vaccine. Exemptions for personal or religious reasons shall be granted upon request of the parent/guardian. The health records of students with exemptions shall be marked for easy identification should the Department of Health order that exempted students be excluded from school temporarily during an epidemic.
4. If a student has not received all of the required immunizations and exemption is not being taken, he/she shall be admitted upon the condition that the schedule of required immunizations has been established and begun. The student's file shall be marked for easy identification and shall be checked at the beginning of the following school year to determine if the schedule of immunization has been completed.
5. If the local Health Department orders the District to exclude a student for noncompliance with the immunization laws and parents have been notified in accordance with WAC 180-40-300, the District shall expel the student pursuant to the due process procedures for emergency student expulsions as defined in WAC 180-40-300. If the parent/guardian requests a hearing, the local Health Department shall be

notified in writing of the time and place for the hearing and a representative of the Health Department shall be present to testify at the expulsion hearing.

D. Sanitation

1. The District will follow guidelines established by the Office of the Superintendent of Public Instruction in the *Infectious Disease Control Guide for School Staff*, the Washington State Department of Social and Health Services, and the U.S. Department of Health and Human Services Center for Disease Control.
2. *Body fluids as sources of infectious agents.* No distinction is made between body fluids from persons with a known disease and those from persons with an undiagnosed illness or without symptoms. Body fluids of all persons should be considered to contain potentially infectious agents. Table I describes examples of infectious agents that may occur in body fluids and the method of disease transmission.
3. In order to avoid contact with body fluids, disposable gloves should be available in school clinics, custodial offices, preschool and childcare classrooms, and first aid kits located in shop areas, school kitchen, physical education locker rooms, classrooms used for home economics, biology, health and any other courses where deemed necessary.
 - a. Gloves should be worn when contacting body fluids, e.g.: treating bloody noses, providing first aid for injuries involving blood or body fluid drainage, changing diapers and ostomy bags and assisting students in managing fecal incontinence, suctioning tracheostomies and handling clothing soils or spills caused by vomit.
 - b. Used gloves should be removed inside out and disposed of in plastic bag or lined trash can. Used tissues, diapers and paper towels should also be placed in a plastic bag for disposal.
4. In the case of unanticipated contact with body fluids when gloves are not available and following the use of gloves, hands and other affected skin areas should be washed with soap and running water with vigorous friction for approximately 30 seconds.
5. Contaminated clothing, towels and other nondisposable washable items should be:
 - a. rinsed and placed in plastic bags before being sent home for washing in the case of personal items.
 - b. in the case of items belonging to the school, laundered at school or by the district laundry service, separate from other items, using soap, hot water and household bleach or other suitable disinfectant used in accordance with manufacturer's instructions. Items sent to the district laundry service should be bagged separately from other laundry and marked "Wash separately with soap and bleach."
6. Contaminated environmental surfaces should be cleaned with a detergent/disinfectant such as Bactisol. Disposable cleaning equipment should be placed in a plastic bag after use for disposal. Used water and disinfectant should be disposed of in a toilet or sewer drain. Nondisposable equipment such as dustpans and buckets should be thoroughly rinsed in disinfectant. After use, mops should be soaked in disinfectant or washed in hot water. Rugs should be cleaned with a germicidal detergent rug shampoo and vacuumed thoroughly.

E. Considerations for Specific Diseases

1. *Common Viral Infection*—Persons with common viral infections such as colds and flu will be advised to remain at home:
 - a. during the acute phase of the illness, and
 - b. for 24 hours following illness accompanied by fever.
2. *Hepatitis B*—In the case of a known student hepatitis B carrier, preexposure vaccination may be recommended

for classroom staff after review by the district's medical consultant. This recommendation would be based on the age of the student and the student's ability to independently handle hygiene needs. A preschool student or older student requiring significant adult assistance in meeting hygiene needs may increase the risk of exposure to hepatitis for staff. In such cases, the cost of the recommended vaccine for staff would be paid by the District.

3. *Acquired Immunodeficiency Syndrome (AIDS)*. Upon identification by a competent medical authority of a person having Acquired Immunodeficiency Syndrome (AIDS), AIDS Related Condition (ARC), or antibodies to the AIDS virus, the following procedures will be followed. These are in accordance with guidelines developed by the Center for Disease Control, the Washington State Department of Social and Health Services, and the American Academy of Pediatrics, and shall be reviewed annually to ensure that the procedures are in accordance with current information known about these conditions.

The following will apply to students:

- a. Students infected with AIDS virus, except for those subject to the conditions described in E. 3. f. below, should be allowed to attend school and before- and after-school care in an unrestricted manner because of the apparent nonexistent risk of transmission of AIDS in these settings.
- b. The infected student should be considered eligible for all rights, privileges and services provided by law and local policy of the School District.
- c. Following consent for release of information provided by the parent or guardian of an infected student, communication will be established with the student's physician. The physician will be able to provide the guidance described in E. 3. d. and E. 3. e. below and will also serve as part of the team described in E. 3. g. to be used in making decisions about preschool or neurologically handicapped children who lack control of their body secretions or who display mouthing behavior such as biting.
- d. The initial decision for school attendance shall be made by an Initial Assessment Team composed of the student's physician, the district's consulting physician, the school health nurse and the school principal after assessment of the situation. This decision shall be reviewed periodically at an interval determined by the Initial Assessment Team. In the case of questionable attendance or disagreement within the Initial Assessment Team, the case shall be referred to the AIDS Review Team described in E. 3. g.
- e. For most infected students, the benefits of a normal school setting would outweigh the risks of their acquiring potentially serious infections in that setting. Assessment of the risk to the immunosuppressed students of attending school in an unrestricted setting shall initially be made by the student's physician who is aware of the student's immune status. The recommendation of the student's physician shall be referred to the district's consulting physician. If the district's consulting physician does not concur with the recommendation of the student's physician, the case shall be referred to the AIDS Review Team described in E. 3. g. below.
- f. A few infected students may potentially pose more of a risk to others. Students who lack control of their body secretions, who display mouthing behavior such as biting or who have other medical conditions, such as uncoverable oozing lesions, require a more restricted environment until more is known about transmission of the virus under these conditions. Individual judgments need to be made regarding placement of students with questionable behavior, impaired neurologic development or other medical conditions in the normal school setting. These decisions shall be referred to the AIDS Review Team described in E. 3. g. below.
- g. The AIDS Review Team shall include the school district's consulting physician; the student's physician; the student's parent(s) or guardian(s); the principal, school nurse, classroom teacher or preschool/childcare program leader from current and proposed educational settings; a physician with expertise in AIDS; and a pediatrician with expertise in infectious disease. The Coordinator of Health Services will be responsible for selecting and convening this team. In each case, risks and benefits to both the infected student and to others will be weighed. *The majority recommendation of the team and any dissenting opinions will be submitted to the Superintendent and Board of Directors for a final decision.*
The District's legal counsel and the student's legal counsel may be members of the team or review the recommendations prior to their submission to the Superintendent and Board of Directors. If at any future time, a member of the AIDS Review Team which reviewed the case of a particular student believes that the condition of that student has changed, the member may request a review to determine if other placement is indicated.
For those students excluded from school attendance, alternative education provisions shall be made available as described by the team.
- h. Those involved in the care and education of AIDS-infected students shall respect the individual's right to privacy and the confidentiality of school and medical records. The persons who are aware of the student's condition should be limited to the minimum needing to know to assure proper care of the child and to detect situations where the potential for transmission may increase (e.g., bleeding injury).
4. *Other Communicable Diseases* The District will follow guidelines established by the Office of the Superintendent of Public Instruction in the *Infectious Disease Control Guide for School Staff*, and the Washington State Department of Social and Health Services.
 - a. The Weekly Communicable Disease Report (Form 401) and telephone notification of major communicable diseases shall be made in accordance with procedures defined in the Federal Way School District Health Services Manual.
 - b. When symptoms of communicable disease are observed in a student while at school, the regular procedure for the disposition of ill or injured students is followed. This procedure is defined in the District Health Room Procedures Manual.
 - c. When the principal or program manager suspects a nuisance disease such as pediculosis (lice), the principal or program manager may institute screening procedures and parent notification in accordance with the District Health Services Manual.
 - d. The length of absence from school for a student ill from a contagious disease is determined by information provided by the Washington State Health Department or instructions provided by the attending physician.

Legal Reference:
 RCW 28A.31.100 through 120—Washington State Immunization Law
 WAC 180-38-005 through 070—Pupils Immunization Requirements

WAC 248-100-163—Immunization of School Children
 WAC 248-101—Communicable Disease
 Adopted: 10/11/79 as Student Immunization
 Amended: 3/23/87 as Communicable Disease

TABLE I
*** Infectious Agents In Body Fluids**

<i>Body Fluid</i>	<i>Organisms of Concern</i>	<i>Method of Transmission</i>
Blood	Hepatitis B virus	Bloodstream inoculation through cuts and abrasions on hands
Cuts/abrasions	AIDS virus	
Nosebleeds	Cytomegalovirus	
Menses		Direct bloodstream inoculation
Contaminated needles		
Feces	Salmonella bacteria	Oral inoculation from contaminated hands
Incontinence	Shigella bacteria	
	Hepatitis A virus	
Urine	Cytomegalovirus	Bloodstream and oral inoculations from contaminated hands
Incontinence		
Respiratory Secretions	Mononucleosis virus	Oral inoculation from contaminated hands
	Common cold virus	
Saliva	Influenza virus	Bloodstream inoculation through cuts and abrasions on hands; bites
Nasal discharge	AIDS virus	
	Hepatitis B virus	
Vomit	Gastrointestinal viruses	Oral inoculation from contaminated hands
Semen	Hepatitis B virus	Sexual contact (intercourse)
	AIDS virus	
	Gonorrhea	
	Chlamydia	
Wound and Eye Drainage	Staphylococcus	Oral inoculation from contaminated hands; direct contact to cut or open wound
	Streptococcus	

* This list contains some, though not all, of the organisms which could be in various body fluids and could cause serious disease.

COMMUNICABLE DISEASES AND IMMUNIZATIONS—EMPLOYEES

P 4040

- 1.0 The Board of Education of the Federal Way School District is committed to providing a healthful environment for all students and employees. To prevent disease transmission and promote a healthy educational/social environment in the District, the Board adopts the policy and guidelines established by the Office of the Superintendent of Public Instruction (OSPI) in the Infectious Disease Control Guide for School Staff. These guidelines provide for the control of the spread of communicable diseases and exclusion from work of any person with a viral or bacterial communicable disease.
- 2.0 Actions taken with respect to employees found to have a communicable disease shall be consistent with rights afforded individuals under State and Federal statutory, regulatory, and Constitutional provisions. Each case shall be treated on an individual basis.
- 3.0 In order to safeguard the school community from the spread of certain vaccine-preventable diseases and in recognition that prevention is a means of combating the spread of disease, the Board strongly urges the immunization of employees (including substitutes) and volunteers.
- 4.0 The Superintendent, or designee, shall be responsible for determining the information to be disseminated to staff, parents, and community when a communicable disease is identified or suspected in the school setting.

- 5.0 The District will continue to revise and update its policy and procedures in accordance with policy changes through the National Centers for Disease Control and the Washington State Department of Social and Health Services, Division of Health. The District will provide current information on communicable diseases and immunizations to staff and students on an ongoing basis.
- 6.0 The Board directs the Superintendent to develop regulations consistent with OSPI's Infectious Disease Control Guide for School Staff, as now or hereafter revised, regarding persons with communicable diseases.

Reference: RCW 28A.31.010

Adopted: 3/13/89

Communicable Diseases and Immunization—Employees R 4040

- 1.0 The District is committed to protecting students and employees from the exposure to communicable diseases that pose serious public health threats.
- 2.0 School officials shall cooperate with the local health department to institute appropriate measures to control or eliminate the spread of a communicable disease in the school population.
- 3.0 At the same time, the District shall protect the employee from discriminatory treatment in the event of any diagnostic health report or finding. King County or the Washington State health departments may exclude employees when they determine that the employee's health condition is

endangering others. All such information shall be treated as confidential.

4.0 *Communicable Diseases (Including Acquired Immune Deficiency Syndrome (AIDS)/Human Immunodeficiency Virus (HIV)*

- 4.1 Upon identification of an employee by a competent medical authority as having a communicable disease the following procedures will be followed:
 - 4.1.1 Any administrator who becomes aware of an employee who has a communicable disease shall immediately inform the director of personnel who shall notify the superintendent.
 - 4.1.2 The director of personnel shall immediately communicate with the employee and request the employee to provide a statement from the employee's personal physician regarding the employee's current health condition.
 - 4.1.3 An employee who has contracted a communicable disease shall be permitted to work upon the approval of the employee's personal physician and the district's designated medical officer under such conditions specified by these medical practitioners. The medical practitioners may choose to seek the advice of officials from King County or Washington State Health Department.
 - 4.1.4 If the need for sick leave is confirmed in writing by the employee's personal physician, an employee may apply for accrued sick leave benefits or sick leave without pay and be granted such leave.
 - 4.1.5 The written notice of intention to return to duty must be accompanied by the employee's physician's statement that the employee is fit to fulfill his/her duties. Such written notice will be submitted to the Director of Personnel and the District designated medical officer for approval.
 - 4.1.6 The employee's immediate supervisor, the Director of Personnel, and if necessary, the employee's personal physician shall meet and confer to determine the extent to which "reasonable accommodation" may be necessary due to the employee's illness.

- 4.1.7 Confidentiality requirements in regard to information about any employee shall be respected and limited to those persons who have "a need to know." Usually, this shall mean the employee's immediate supervisor, the Director of Personnel, and the Superintendent.

5.0 *Staff Immunizations: Vaccine-Preventable Diseases*

- 5.1 In order to safeguard the school community from the spreading of certain communicable diseases and in recognition that prevention is a means of combating the spreading of such diseases, the Board strongly recommends that all susceptible employees (including substitutes) and volunteers provide evidence of immunity to vaccine preventable diseases. For purposes of this policy, in regards to measles, "susceptible" means any employee who was born after January 1, 1957. This documentation shall be collected and maintained by the Personnel Department.
- 5.2 A susceptible staff member may be exempt from the requirements for immunization by filing a written objection to such immunization on the basis of religious grounds, personal reasons or when a private physician certifies that the employee's physical condition contraindicates immunization.
- 5.3 In the event of an outbreak of a vaccine-preventable disease, the local health officer has the authority to exclude a susceptible employee. Exemptions granted for religious or medical reasons are not sufficient grounds for granting a waiver of an exclusion. A staff member who is excluded is eligible to use accrued leave benefits for such purposes.
- 5.4 All employees should complete the Immunization History for School Personnel form and send to the Personnel Department.

Legal Reference:

WAC 248-101-220 Control of Communicable disease

Adopted: 3/13/89

Appendix G

Surveys of AIDS/HIV Education Programming

Version 3 - 14 March 1991

Survey of AIDS/HIV Education Programming

School Principal

The following questions are designed to identify the educational policies and programs that have been instituted at your high school. Please answer all questions.

	Yes	No	To a degree, but needs improvement		Yes	No	To a degree, but needs improvement
1. Has a policy for attendance of students and staff with AIDS/HIV infection been adopted, published, and circulated?	☐	☐	☐	15. Have in-service programs on AIDS/HIV infection education been provided to health education teachers?	☐	☐	☐
2. Has a policy ensuring confidentiality of individuals with AIDS/HIV been adopted, published, and circulated?	☐	☐	☐	16. Have in-service programs on AIDS/HIV infection education been provided to school nurses?	☐	☐	☐
3. Has an infection control policy (to manage body fluid spills) been adopted, published, and circulated?	☐	☐	☐	17. Have specific inservice programs on the management of body fluids been provided to janitors, school nurses, and school secretaries?	☐	☐	☐
4. Is AIDS/HIV instruction mandated by state or local policy?	☐	☐	☐	18. Have in-service programs on AIDS/HIV infection education been provided to all other faculty, staff, and administrators?	☐	☐	☐
5. Has a policy on AIDS/HIV instruction been implemented in your school program?	☐	☐	☐	19. Have procedures and/or protocols for HIV infection control (to manage body fluid spills, etc.) been implemented in your school?	☐	☐	☐
6. Have AIDS/HIV policies for students and staff been developed with input and/or consultation from community representatives?	☐	☐	☐	20. Are first aid kits with appropriate equipment such as cleansing solution and vinyl or rubber gloves, readily available at appropriate locations in the school?	☐	☐	☐
7. Have the display cases, the public address system, or posters been utilized in an AIDS/HIV public awareness campaign?	☐	☐	☐	21. Has the school district established an emergency response team to provide service to students, staff, and media in the event of an inadvertent disclosure of an individual with AIDS/HIV infection in the school?	☐	☐	☐
8. Has the school board policy on AIDS/HIV infection prevention been explained to the community?	☐	☐	☐	22. Is there a mechanism for distributing condoms to students in the school setting?	☐	☐	☐
9. Have there been any student assemblies or after school programs devoted to preventing AIDS/HIV infection?	☐	☐	☐	23. Is there a policy on referring students to a community site for contraceptive information and condoms?	☐	☐	☐
10. Have local STD clinics and/or anonymous testing sites been identified in the student handbook?	☐	☐	☐	24. Has AIDS/HIV instruction been implemented in your school program?	☐	☐	☐
11. Has the school developed programming for an AIDS/HIV Awareness Week or Day?	☐	☐	☐	25. Have AIDS/HIV education programs for students been developed with input and/or consultation from parents?	☐	☐	☐
12. Has the prevention of AIDS/HIV infection been discussed at PTA meetings?	☐	☐	☐	26. Has the AIDS/HIV curriculum for students been developed with input and/or consultation from a committee of teachers?	☐	☐	☐
13. Have parent education and/or training programs for issues surrounding the prevention of AIDS/HIV infection been conducted?	☐	☐	☐	27. Has the AIDS/HIV curriculum for students been developed with input and/or consultation from a committee of community representatives?	☐	☐	☐
14. Has a school-community task force to develop programming to prevent AIDS/HIV infection been organized?	☐	☐	☐	28. Has the AIDS/HIV curriculum been developed with input and/or consultation from students?	☐	☐	☐

The development of this instrument has been sponsored by a grant from the American Foundation for AIDS Research.

Survey of AIDS/HIV Education Programming**School Nurse**

The following questions are designed to identify the educational policies and programs that have been instituted at your high school. Please answer all questions.

	To a degree, but needs improvement			To a degree, but needs improvement		
	Yes	No		Yes	No	
1. Has the nursing service staff implemented a school policy for infection control (to manage body fluid spills)?	☐	☐	☐	☐	☐	☐
2. Has the nursing service staff implemented a school policy insuring confidentiality for individuals with AIDS/HIV infection?	☐	☐	☐	☐	☐	☐
3. Has the school health services staff provided instruction or counseling on reproductive health to students?	☐	☐	☐	☐	☐	☐
4. Has the school clinic and/or nursing room been used to provide students with reproductive health services (e.g., STD testing, contraceptives)?	☐	☐	☐	☐	☐	☐
5. Has the health service staff provided students with material describing access to local STD clinics?	☐	☐	☐	☐	☐	☐
6. Has the health service staff provided students with material describing the location of anonymous testing sites for AIDS/HIV?	☐	☐	☐	☐	☐	☐
7. Have procedures for referral of students to anonymous HIV testing sites been established?	☐	☐	☐	☐	☐	☐
8. Does the school health clinic have a policy regarding contraceptive counseling?	☐	☐	☐	☐	☐	☐
9. Has the health service staff used the display cases, the public address system, or posters in an AIDS/HIV awareness campaign?	☐	☐	☐	☐	☐	☐
10. Has the school health clinic been used to display posters or pamphlets about preventing AIDS/HIV infection?	☐	☐	☐	☐	☐	☐
11. Has the health service staff assisted students who identify themselves as being at risk for AIDS/HIV infection by providing specific educational programming?	☐	☐	☐	☐	☐	☐
12. Are local STD clinic and/or anonymous testing sites identified in the student handbook?	☐	☐	☐	☐	☐	☐
13. Has the health service staff assisted the school in developing programming for an AIDS/HIV Awareness Week or Day?	☐	☐	☐	☐	☐	☐
14. Has the health service staff distributed material describing infection control (managing body fluid spills, etc.) to the school staff?	☐	☐	☐	☐	☐	☐
15. Has the health service staff assisted in providing the staff in-service training for infection control procedures?	☐	☐	☐	☐	☐	☐
16. Has the nursing staff been involved in collaborative school-community programming to prevent the spread of HIV infection among school youth?	☐	☐	☐	☐	☐	☐
17. Have professionals in the community been used by the nursing staff to deliver AIDS/HIV instruction in the school?	☐	☐	☐	☐	☐	☐
18. Has the health services staff received training that focuses on how to conduct in-service programs that deal with preventing AIDS/HIV infection?	☐	☐	☐	☐	☐	☐
19. Has the nursing staff been involved in the development of student assemblies or after school programs devoted to preventing AIDS/HIV infection?	☐	☐	☐	☐	☐	☐
20. Has the nursing staff assisted in the development of peer counseling and/or instruction programs to address AIDS/HIV infection?	☐	☐	☐	☐	☐	☐
21. Have procedures and/or protocols for infection control (managing body fluid spills, etc.) been established?	☐	☐	☐	☐	☐	☐
22. Are first aid kits with appropriate equipment such as cleansing solution and vinyl or rubber gloves readily available at appropriate locations in the school?	☐	☐	☐	☐	☐	☐
23. Has the health services staff provided classroom instruction to students on preventing AIDS/HIV infection?	☐	☐	☐	☐	☐	☐
IF YES, please estimate:						
The number of classes per year _____						
The number of students reached _____						
If YES, was the instruction provided:						
as supplemental to the planned course of study? ☐ ☐						
as a portion of the planned course of study? ☐ ☐						
as a separate instructional program? ☐ ☐						

The development of this instrument has been sponsored by a grant from the American Foundation for AIDS Research.

Survey of AIDS/HIV Education Programming**School Counselor**

The following questions are designed to identify the educational policies and programs that have been instituted at your high school. Please answer all questions.

- | | Yes | No | To a degree,
but needs
improvement |
|--|--------------------------|--------------------------|--|
| 1. Have display cases in the guidance office been used to raise AIDS/HIV awareness? | ☐ | ☐ | ☐ |
| 2. Does the school have a policy on counselors addressing and/or instructing students on reproductive health? | ☐ | ☐ | ☐ |
| 3. Has the counseling staff provided students with material describing the location of anonymous testing sites for AIDS/HIV infection? | ☐ | ☐ | ☐ |
| 4. Has the counseling staff provided material describing access to local STD clinics to all students who inquired? | ☐ | ☐ | ☐ |
| 5. Have procedures for referral of students to anonymous HIV testing sites been established? | ☐ | ☐ | ☐ |
| 6. Does your counseling staff have a protocol in place to make confidential STD/AIDS student referrals (other than for testing sites) to appropriate community agencies? | ☐ | ☐ | ☐ |
| 7. Does the counseling staff know to whom confidential STD/AIDS student referrals should be made? | ☐ | ☐ | ☐ |
| 8. In general, does the counseling staff have the capability of making STD/AIDS referrals in a <i>nonjudgmental</i> manner? | ☐ | ☐ | ☐ |
| 9. Has the counseling staff assisted students who identified themselves as being at risk for AIDS/HIV infection for specific educational programming? | ☐ | ☐ | ☐ |
| 10. Has the counseling staff assisted in the development of peer counseling and/or instruction programs to address AIDS/HIV infection prevention? | ☐ | ☐ | ☐ |
| 11. Has the counseling staff assisted in the development of an AIDS/HIV Awareness Week or Day? | ☐ | ☐ | ☐ |
| 12. Has the counseling staff been involved in collaborative school-community programming to prevent the spread of HIV infection among school youth? | ☐ | ☐ | ☐ |
| 13. Have professionals in the community been called upon by the counseling staff to deliver AIDS/HIV instruction in the school? | ☐ | ☐ | ☐ |
| 14. Has the counseling staff received in-service programs that focused on preventing AIDS/HIV infection? | ☐ | ☐ | ☐ |
| 15. Has the counseling staff been involved in the development of student assemblies or after school programs devoted to preventing AIDS/HIV infection? | ☐ | ☐ | ☐ |

16. Has AIDS/HIV instruction been provided as part of the school guidance program?

To a degree,
but needs
Yes No improvement

If YES, please estimate:

the number of classes per year _____

the number of students reached _____

If YES, was the instruction provided:
as a supplement to the planned course
of study? ☐ ☐

as a portion of the planned course of
study? ☐ ☐

as a separate instructional program? ☐ ☐

The development of this instrument has been sponsored by a grant from the American Foundation for AIDS Research.

Survey of AIDS/HIV Education Programming**Health Teacher**

The following questions are designed to identify the educational policies and programs that have been instituted at your high school. Please answer all questions.

	Yes	No	To a degree, but needs improvement
1. Is AIDS/HIV instruction mandated by local school system policy?	☐	☐	☐
2. Have health classroom bulletin boards been used by the health education staff to reinforce the AIDS/HIV curriculum?	☐	☐	☐
3. Have display cases, the public address system, or posters, been utilized by the health education staff in an AIDS/HIV public awareness campaign?	☐	☐	☐
4. Has material been provided in health classes describing access to local STD/HIV clinics and/or anonymous testing sites?	☐	☐	☐
5. In general, is the health education staff capable of providing confidential and nonjudgmental referral to those seeking STD/AIDS information?	☐	☐	☐
6. Has the health education staff assisted in the development of programming for an AIDS/HIV Awareness Week or Day?	☐	☐	☐
7. Has the health education staff assisted other teachers in providing AIDS/HIV instruction?	☐	☐	☐
8. Has the health education staff been involved in the development of student assemblies or after school programs devoted to preventing AIDS/HIV infection?	☐	☐	☐
9. Is the health education staff capable of assisting students for specific education programming who identify themselves as being at high risk for AIDS/HIV infection?	☐	☐	☐
10. Has the health education staff called upon professionals in the community to deliver AIDS/HIV instruction in the school?	☐	☐	☐
11. Has the health education staff assisted in the development of peer counseling and/or instruction programs to address AIDS/HIV infection?	☐	☐	☐
12. Have AIDS/STD instructional lessons been taught by health educators?	☐	☐	☐
13. As a classroom exercise, have students conducted a self-assessment of their behavior regarding AIDS/HIV?	☐	☐	☐
14. Has the AIDS/HIV curriculum for students been developed with input and/or consultation from parents?	☐	☐	☐
15. Has the AIDS/HIV curriculum for students been developed with input and/or consultation from a committee of teachers?	☐	☐	☐
16. Has the AIDS/HIV curriculum for students been developed with input and/or consultation from students?	☐	☐	☐
17. Has the AIDS/HIV curriculum for students been developed with input and/or consultation from community representatives?	☐	☐	☐
18. Were the AIDS/HIV education programs implemented with input and/or consultation from parents?	☐	☐	☐
19. Were the AIDS/HIV education programs implemented with input and/or consultation from teachers?	☐	☐	☐
20. Were the AIDS/HIV education programs implemented with input and/or consultation from students?	☐	☐	☐
21. Were the AIDS/HIV education programs implemented with input and/or consultation from community representatives?	☐	☐	☐
22. Has the health education staff received in-service training focusing on AIDS/HIV infection prevention?	☐	☐	☐
23. Do elementary teachers (K-6) provide AIDS/HIV instruction to students?	☐	☐	☐
24. Do junior high teachers provide AIDS/HIV instruction to students?	☐	☐	☐
25. Does the AIDS/HIV instructional program emphasize responsible decision making, skill development, assertiveness training, and self-esteem rather than biomedical knowledge?	☐	☐	☐
26. Have resource materials been developed for parents to use to supplement lessons received at school?	☐	☐	☐
27. Has the health education staff encouraged student groups to focus on AIDS/HIV issues in appropriate extracurricular activities (e.g., drama presentations, school newspaper articles)?	☐	☐	☐

The development of this instrument has been sponsored by a grant from the American Foundation for AIDS Research.



American School Health Association